MC0362

BEST BUY HOSPITALS
MARK I
EVALUATION REPORT

POLICIES AND DESIGN

1978

DHSS

1980

£9.15p

CONTENTS

An Evaluation of the Best Buy Hospitals: 1978

		Page
1	INTRODUCTION	1
2	METHODOLOGY	7
3	BACKGROUND AND GENERAL INFORMATION	16
4	PLANS - BEST BUY HOSPITALS	23
5	ACUTE IN-PATIENTS, PSYCHIATRIC, GERIATRIC AND OBSTETRIC SERVICES:	29
	- GENERAL ACUTE BEDS	"
	- OBSTETRICS DEPARTMENT	41
	- CHILDREN'S BEDS AND 'SWING'-UNIT	50
	- PSYCHIATRY DEPARTMENT	54
	- GERIATRICS	62
	- ISOLATION UNIT	67
	- INTENSIVE THERAPY UNIT	71
6	OUT-PATIENTS AND DAY PATIENTS:	76
	- GENERAL AND DENTAL OPD	"
	- OBSTETRICS AND GYNAECOLOGY OPD	"
	- ACCIDENT AND EMERGENCY DEPARTMENT	86
	AND ORTHOPAEDIC AND FRACTURE CLINIC	"
	- DAY AND EMERGENCY UNIT	91
7	TREATMENT AND DIAGNOSTIC SERVICES:	95
	- CENTRAL TREATMENT SUITE	"
	- OPERATING THEATRES, RECOVERY AND TSSU	100
	- X-RAY DEPARTMENT	108
	- PATHOLOGY DEPARTMENT AND MORTUARY	111
	- DEPARTMENT OF PHYSICAL MEDICINE	116
8	PHARMACY	126
9	CATERING AND DIETETICS	130
10	ENGINEERING, WORKS, MAINTENANCE AND DISPOSAL	137
11	SUPPLIES, STORAGE AND DISTRIBUTION	143
12	EDUCATION AND TRAINING	150
13	STAFF FACILITIES	156
14	GENERAL AMENITIES	161
15	PATIENT SERVICES:	164
	- MEDICAL RECORDS	
	- PATIENT RECEPTION, ADMISSION AND DISCHARGE	
	- MEDICAL SECRETARIES	

MARU
THE POLYTECHNIC
OF NO

16 HOUSEKEEPING 168

17 ADMINISTRATION: 175

- GENERAL ADMINISTRATIVE MANAGEMENT STRUCTURES
- MEDICAL ADMINISTRATION
- NURSING ADMINISTRATION
- PORTERING AND TRANSPORT
- VOLUNTARY SERVICES
- SOCIAL SERVICES

18 OFF-SITED SERVICES: 195

- LAUNDRY
- CSSD
- SUPPLIES

19 CONCLUSIONS: 203

- GENERAL CONCLUSIONS
- RECOMMENDATIONS

20 REFERENCES 214

21 APPENDIX 1: 216

- QUALITY AND ENVIRONMENT - a general commentary

FOREWORD BY DHSS

The report which follows is comprehensive and largely self-explanatory. In the past few years there have been several major studies which reflect the Department's resolve to put its twin "Best Buy" projects at Bury St Edmunds and Frimley under a microscope and learn from them as much as possible for the benefit of other planners and designers, particularly those concerned with Nucleus developments.

Evaluation is of course that putative final stage in the hospital building process which often gets submerged by resource constraints, the immediacy of patient care, or whatever. The local staffs in both Districts have had to overcome such deterrents through a sustained enthusiasm for the project and their willingness to contribute to its evaluation is highly creditable. Without such collaboration there might always have been room for conjecture about how far the project had achieved its objectives, those objectives of economy with efficiency which kept it in the forefront of publicity for many years.

In the late 1960s the Department's Project Team was having no truck with the viewpoint that costs cannot be cut without some lamentable effect or other. Their commitment was to seek the utmost saving without detriment to standards of care or environment; by and large they succeeded, although the main benefit - in terms of advancing the hospital building programme nationally - could not be realised at the time. But the wheel of economic fortune has turned full circle and brought the better use of resources into the limelight once again.

The Team's constant regard for their objectives provides the background against which the results must now be appraised. The introduction to this report acknowledges (p 2) that "The nature of the research methodology automatically reveals faults and dissatisfaction rather than praise. To redress the balance it should be pointed out that staff were generally extremely pleased with their environment and that by all accounts the hospitals were well liked by the patients and the local populace".

A more balanced picture is also to be found in the final conclusions. Nevertheless, the fact that the report has to depend mainly on subjective user reactions may leave the reader who chooses to sample only a few sections uncertain as to:-

a. how familiar the staff interviewed may have been with the design intent and its emphasis on strict economy;

b. the comparative basis of their planning criticisms, whether it was the older and smaller hospitals replaced by Best Buy or perhaps some newer building elsewhere of more extravagant standards; and

c. whether the organisational defects also being drawn into those criticisms, were acknowledged for attention by local management.

In effect this is to say that sampling should be a matter of some caution. With that reservation the report can be commended for its relevance to the NHS capital programmes of today and for presenting a gratifyingly broad picture to complement the other, more specific surveys.

Before these Mk 1 Best Buys were completed, design work on a Mk 2 version was under way and the first such hospital has been built at Kings Lynn. Among the studies now being undertaken is a mainly graphical comparison between the two versions, department by department. It illustrates the considerable extent to which the alleged shortcomings of Mk 1 have been remedied - not without some loss of the extreme economy, of course - and in due course it should make a worthwhile adjunct to this report.

GLOSSARY

It is impossible, within the limits of this commission, to explain in detail all the terms and abbreviations used in this report, and it has been assumed that the reader will either be familiar with their meaning or will have access to the Planning Policies, or to other descriptions.

It is thought valuable to note the following (not in any order of importance):

Region	=	Regional Health Authority (RHA)
Area	=	Area Health Authority (AHA)
District	=	Area of responsibility and management into which an Area is broken down, eg District Management Team (DMT)
Sector	=	The district general hospital and various other facilities in management terms
Unit (DGH)	=	The district general hospital (DGH) from which or to which a service operates
OPD	=	Out-Patients Department
A & E	=	Accident and Emergency Department
D & E	=	Day and Emergency Beds and Department
CTS	=	Central Treatment Suite
Op Th	=	Operating Theatres
TSSU	=	Theatre Sterile Supplies Unit
SCBU	=	Special Care Baby Unit
ITU (ICU)	=	Intensive Therapy (Care) Unit
Physical Medicine	=	Occupational Therapy, Physiotherapy and some Rheumatology
ECT	=	Electro-convulsive therapy
CSSD	=	Central Sterile Supplies Department
wte	=	Whole Time Equivalent - staffing establishments

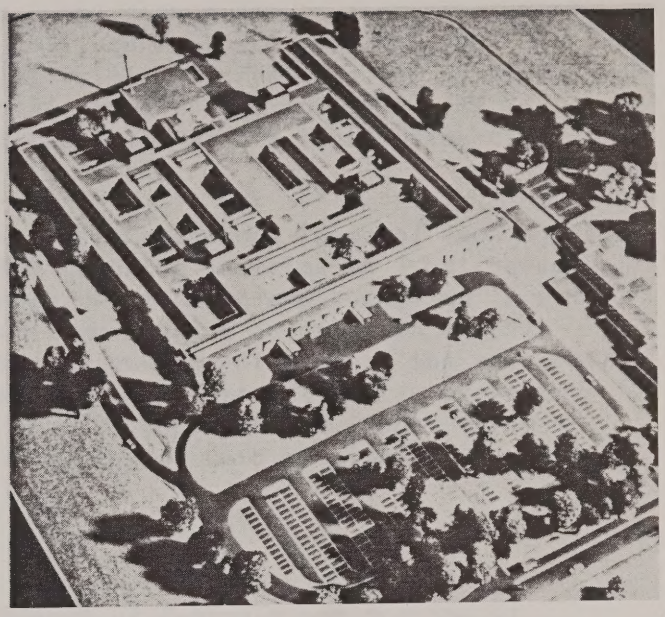
Catering

Bulk Food Service	=	Meals sent as bulk prepared foods in heated trolleys to be individually served at their destination
Plated Meals Service	=	Meals partially or completely allocated and divided in the kitchen as individual portions served on plates and sent by heated or non-heated trolley to their destination

Nursing

Barrier Nursing	=	A discipline designed to minimise cross-infection
Progressive Patient Care	=	A system or organisation in which there are 3 areas of patient care, viz: high, medium and low dependency

Introduction.



AN EVALUATION OF THE BEST BUY (MARK 1) HOSPITALS: 1978

INTRODUCTION

This report is the outcome of a short-term commission given to a multi-disciplinary team of consultants* in November/December 1977, to evaluate the 'Best Buy' Hospitals at Bury St Edmunds, Suffolk and at Frimley, Surrey, in the context of the 'Best Buy' planning principles written between 1968 and 1970, and in relation to the hospitals' present mode of operation within their respective catchment areas.

In agreement with the DHSS and with the District Management Teams of each hospital, it was decided to examine the final detailed Planning Policies at 'whole hospital' and 'service/departmental' levels; to discuss development and change at 'service/departmental' levels; to examine and obtain commentative information on the present validity and appropriateness of the design and policies of the services/departments - as they were envisaged - from members of staff; and to present in suitable form to the DHSS and to the hospitals concerned, a report for discussion which would contrast the present situation of both hospitals but would not attempt a direct comparison.

ACKNOWLEDGEMENTS

The surveys were carried out between the middle of February and the end of March 1978.

The team would like to express their gratitude to the District Management Teams and to every member of staff who contributed so efficiently and enthusiastically, at a particular busy time of year, to the visit, the interviews, the discussions and to the information received.

Thanks are also due to the staff at Hospital Design Partnership, the 'Best Buy' evaluation team at the Department of Health and to the researchers at the Medical Architecture Research Unit - all of whom contributed, co-operated and guided at vital stages of the research.

Inevitably, many people who would have liked to contribute to the study were unable to do so because of absence or illness or because of the tight schedule of interviews held in such a short period of time. Particular apologies are tendered to the medical staff, the portering and transport staff and any others who would have liked to contribute but were not interviewed; they are welcome to comment on the report.

CONCLUSIONS

The two hospitals have developed and changed in many ways and each should be reviewed in the light of considerable changes taking place in the respective catchment areas.

A massive increase in local population served by Frimley hospital and the changes of boundary and organisation of back-up services over a large rural area at Bury St Edmunds have had particularly marked effects on the acute nature of hospital treatment and care.

These factors, coupled with the problems of National Health Service re-organisation, the re-organisation of nursing duties (Salmon), new EEC legislation and general legislation in this country on the control of fire and conditions of work, have seriously affected the operational policies and inter-communication between staff. However, despite the problems, most people appear to be adjusting to the changes and the hospitals appeared to be accommodating space-use and organisational changes in a flexible manner.

The nature of the research methodology automatically reveals 'faults' and 'dissatisfaction' rather than praise. To redress the balance it should be pointed out that staff were generally extremely pleased with their environment and that by all accounts the hospitals were well liked by the patients and the local populace.

It was outside the scope of this study to carry out patient interviews. It is an important omission and it is fully recommended that a suitable research programme should be set up to obtain feedback from the patients - in particular it should be valuable to speak to those who were moved into the new hospitals at the time of commissioning.

NOTE

Although it was part of the aims of the evaluation to assess changes in design, policy, organisation and administration, the research team's ultimate point of reference was to assess the use and success of the Planning Policies, not to carry out any study on staffing management or organisation.

Facts and statistics have been included where available, but no in-depth analysis is given.

Christopher Edwards
HOSPITAL DESIGN PARTNERSHIP 1978

* Department of Health and Social Security
Best Buy Planning Evaluation Group
Liaison Officer: John Ward
Research Team/Consultant : Mike McNamara

Architects
Hospital Design Partnership
Partner/Supervisor : Paul James
Research Co-ordinator : Christopher Edwards

Nurse Planning Consultants/Research Team
Mary Le Q Mitchell
Margaret McCutcheon

PREAMBLE

The objectives of the evaluation were several, stemming from the 6 main principles laid out in the 'Best Buy' document on planning:

Function
Economy
Efficiency
Quality
Environment
Speed

These qualities of 'Best Buy' hospital planning are essential to the success or failure of the whole exercise - undertaken by the Designers, DHSS and others - in which a degree of explanation and examination of the way a hospital might work was presented through the planning policies to a greater degree of detail than has ever been done elsewhere. The hospitals concerned are the DGH's at Bury St Edmunds and Frimley, Surrey.

Since the policies were written changing circumstances have affected them, and although still 'models' for current practice they could be rewritten. Observing the motive for the building of such hospital facilities in the first instance, the 'Best Buy' concept has retained a quality of functional performance, purpose, human scale and environmental completeness, that was part and parcel of the sincerity of the planners and architects.

As much of the success of the hospitals (as indicated by our research) is due to medical, nursing, administrative and other staffing as it is to the architect; despite the strait jacket of financial savings and functional compromises, they present a greater capacity for flexibility and change than was ever expected.

In particular one must recognise the effects of NHS re-organisation; the re-structuring of the nursing administration and the effect of changes in Community Care; changes in public attitude towards Health Services; and the statistical impact of growth in each catchment area's population.

Our terms of reference were:

1 To establish if the original objectives of the 'Best Buy' Hospitals have been achieved.

2 To evaluate the measure of success or failure and the reasons for each.

3 What lessons to be learnt?

eg Guidance material
Level of provision
Future planning
Commissioning
How can this material and experience best be exploited?

In detail our terms of reference covered:

<u>Function and Efficiency</u> including:

1 Relation of the hospital to the whole community.

2 Anticipated catchment area and population.

3 Present catchment area and population.

4 Pattern of care as seen through the whole hospital policies.

5 Actual pattern of care and any relevant changes.

6 Relationship of departments.

7 The design efficiency and adequacy of each department.

Further to these main points, the report will cover the two following aspects:

a. Quality and Environment including:

Performance of structure
Maintenance implications
Finishes
Damage
Changes of use
Scale
Interior design
Landscaping

b. Speed and Economy related to Contract Planning

BEST BUY HOSPITALS AT BURY ST EDMUNDS, SUFFOLK AND AT FRIMLEY, SURREY: A general description

---

The Best Buy hospitals were planned as part of an integrated community health service in which all three branches of the National Health Service - the hospital, the local authority and the general practitioner services - played their full part.

2 acute beds/1000 population were adopted as a norm for general in-patient provision and the population estimate of 170,000 served by each hospital represented a prediction for some years ahead of the time when the hospitals would come into use.

The twin prototype Best Buy hospitals at Bury St Edmunds and Frimley were each built complete in one building phase in a period of approximately three years. The total floor area of each hospital is 30,000 square metres. They provide the following range of content:

550 : acute beds (medical, surgical, obstetric, paediatric, psychiatric and geriatric)
6 : operating theatres suites and ancillary accommodation
6 : X-Ray diagnostic suites and ancillary accommodation
8 : bed intensive therapy/coronary care unit
accident and emergency department
consultative out-patient department and day surgery unit
full range of laboratories
physical medicine department
full range of supporting services (including supplies, catering, pharmacy, management and education departments)

The Best Buy design allows for considerable variation in the range of functional content and for limited expansion and adaptation.

The Department of Health and Social Security research and development project aimed at rationalising the health services in the two areas; the two identical hospitals are each conceived as part of an integrated community health service ensuring that:

1 As many patients as possible are investigated and treated in the community by family doctors helped by local authority nurses and health visitors.

2 When patients are referred to hospital, the optimum use of out-patient diagnostic and treatment facilities (including day beds) should enable more of them to be treated as out-patients.

3 When admission is essential, in-patient stay could be shortened by good bed management and by planned early discharge. By planning on these premises and 'hotel' side of the hospital care could be reduced (the acute bed provision at Bury St Edmunds and Frimley is based on 2 beds per 1000 population instead of the previously accepted ratio of 3 per 1000) while, at the same time, the throughput of the diagnostic and treatment departments could be increased by planning these departments for more intensive use.

A further factor contributing to a reduction in the overall size of the hospitals is the development of regional policies under which essential 'industrial' services (eg laundries, pharmacies, sterile supply departments etc) are now being organised on an area basis serving several hospital groups from conveniently located 'industrial' sites away from the hospitals. Neither at Bury St Edmunds nor at Frimley are to be found those extensive ancillary building complexes housing laundries and large steam producing plants with their inherent problems of noise, dirt and constant disturbance from heavy vehicles.

It was these significant planning economies together with the determination of the project team - 'to seek the utmost in economies in whole hospital design and construction ... and a proper balance between capital and running costs' - which led to the hospitals being dubbed 'Best Buy'. In the event, at tender stage, the contract price of each hospital was some 30 per cent below the Department of Health and Social Security's cost limit for a hospital of conventional design planned to serve a population of the same size.

Methodology.

GENERAL INTRODUCTION

Following the planning and commissioning of the two Best Buy Mark 1 hospitals in the early 1970's, the DHSS have instigated a series of 'feedback' research projects concerned with establishing the current validity of their initial planning strategies, and in order to obtain vital user response from the first years' operation of each hospital.

It is worth pointing out that because of the many particular attributes, problems and solutions of organisation and design of these first two 'model' DGH's at Bury St Edmonds and Frimley the hospitals have become valuable, if rather long-suffering showpieces. This has made them quite a focus of public and individual criticism within and without the hospitals, it has attracted many visitors, and they have become an obvious model for research.

Since the offical dates of commissioning: (31 July 1972 for Bury St Edmunds and 31 August 1973 for Frimley) numerous studies, reports and actions have been undertaken by or on behalf of each hospital, or at the wish of the Department of Health and Social Security. Where we have been informed of any such 'research' we have included this in the list of references.

At the time of undertaking this evaluation there were two other current research projects taking place which concerned the Best Buy Mark 1 hospital. Commissioned by DHSS and undertaken by the Medical Architecture Research Unit, they were 'Space Utilisation in Hospitals' and an 'Evaluation of Supply and Disposal in the Best Buy Hospitals'.

It became obvious that whilst these studies would provide vital observation both generally and in detail on the management and organisation of the hospital spaces and services, another kind of perspective was needed which looked at the integration of the architecture with the written policies of operation and which placed the hospitals in context with the community they served. Hospital Design Partnership as architects to Bury St Edmunds and Frimley were commissioned to undertake this 'Evaluation of the Best Buy Hospitals', and throughout the exercise used as monitors two essential documents:

'The Rationalisation of Planning and Design'
Ministry of Health. March 1968

'Final Detail Planning Policies - Best Buy Hospitals'
written between 1969 and 1972

The other document of particular reference is:

'The Inter-Relationship of Hospital and Community Services in Best Buy Planning'
Report BB6. May 1971. DHSS

The following 'Best Buy' principles and objectives are extracted from the

'Rationalisation of Planning and Design' report of 1968;

they served as the monitors for the purposes of this evaluation.

1.1 Increase productivity of planners/designers.
One solution to satisfy requirements for two areas with minimal variation.

1.2 To identify features for application elsewhere.

2.1 The application and improvement of co-ordinated patient care.

2.2 More intensive use of hospital beds and treatment facilities.

2.3 Maintain standards of medical/nursing care.

3.1 Utmost economy in design/construction.

4.1 Standard of design appropriate to function.

5.1 Full use of existing hospital facilities - these to be upgraded if necessary, and where feasible.

6.1 Efficient internal organisation - design criterion.

6.2 Full amenities for patients.

6.3 Pleasant staff working conditions.

The objectives of the research team were to investigate the match or mismatch between:

Final Detail Planning Policies
Commissioning/Operational Policies
Current Operational Policy

The Planning Policies were the operative documents, compiled by Administrative Managerial, Nursing, Medical and Architectural teams with input as relevant from other disciplines and from Community and Local Authority Services, Engineering and Surveying teams. These were the documents used by the Architects to help them prepared detailed departmental plans, so the policies and the plans should be considered together.

The policies are made up of five sections:

1 Off-sited supporting services

2 Whole Hospital Functions and Departments

a. Access and Communications
b. Boiler Plant/Engineering Services
c. Cleaning/Maintenance/Works
d. Delivery of Supplies/Disposal/Stores and Pharmacy
e. Catering
f. Facilities for Staff
g. Education Centre and Library
h. Administration
j. Medical Records/Appointments/Admissions and Discharges
k. Welfare of Patients and Visitors
l. The Development Plan and Departmental Relationships

3 In-Patient Nursing Units

a. General Acute
b. Maternity
c. Children
d. Psychiatric
e. Geriatric
f. Infectious Diseases

4 Out-Patients and Day Patients

a. Main OPD and Dental
b. Ante-Natal and Gynaecology Clinics
c. Orthopaedic/Fracture Clinics
d. Accident and Emergency Department
e. Day/Emergency Unit

5 Treatment and Diagnostic Services

a. Central Treatment Rooms
b. Operating Theatres and Recovery
c. Intensive Therapy Unit
d. Clinical Investigation
e. X-Ray/Thermography
f. Pathology and Mortuary
g. Department of Physical Medicine

The Operational Policies show how the pattern of organisation relates to the design of the whole hospital. These policies were intended to prevail following the completion of the building work and the commissioning.

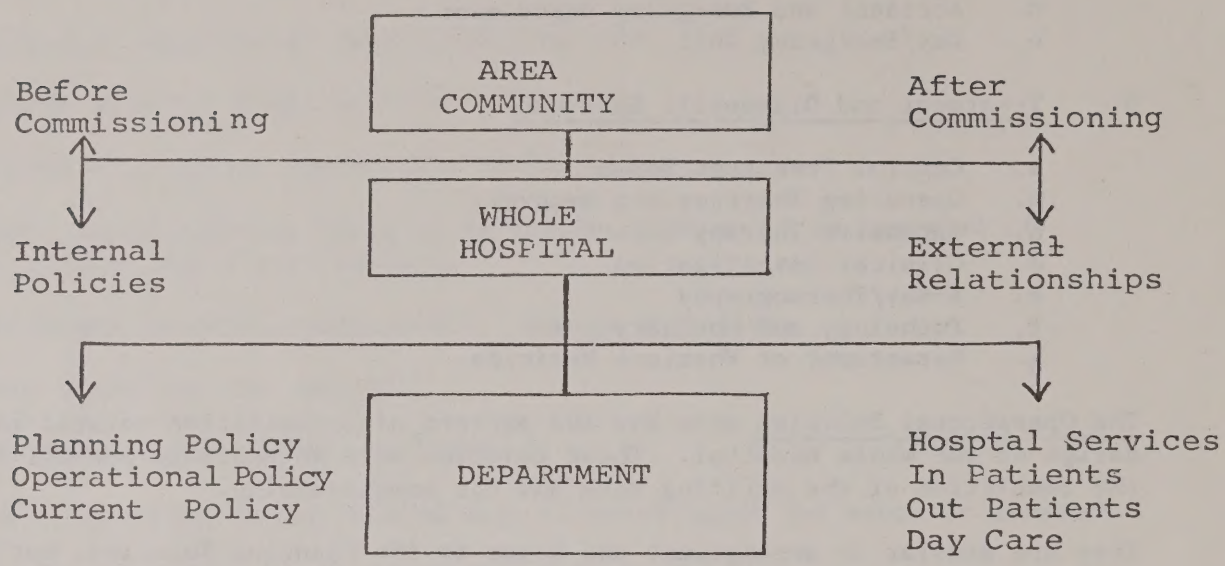
They are similar in arrangement and scope to the Planning Policies, but in that respect are more succinct, dealing in greater detail with on-site hospital and departmental problems.

The Commissioning teams "do not intend that these policies should be regarded as inflexible regulations, but take the view that they may need amendment as the wards and departments of the hospital are brought into full operation, and actual working conditions are observed".

Current Operational Policies are those which represent the actual operating conditions at the time of investigation. There will probably be adjustment, alteration and modification of the 'model' or 'patterns' laid out in the Operational/Commissioning Policies, and conditions will further be modified by external and internal environmental and architectural features and idiosyncracies pertaining to each hospital.

The assessment of what are the current Operational Policies will not be exhaustive, or in any way scientific. It will merely be an observation of valid current practice as corroborated by statement and observation.

SCOPE OF RESEARCH FINDINGS



NOTE : THE QUALITY AND VALIDITY OF THE REPORT :

Whilst the object of the evaluation was to test the validity of the Best Buy principles and Planning Policies with the situation and practice that have developed in each hospital, a standard approach had to be adopted for interviewing in order to obtain some degree of consistency in response, and in order to maintain the conformity of the evaluation team's approach.

Inevitably the order of questions and the way in which information was revealed or offered varied from person to person, and staff obviously chose to take us round the departments (at our request) when it was most convenient. But, as has been said elsewhere, the timing of the visits to both hospitals was very tight and very demanding on both the team and the people they interviewed. These factors must be considered when the content and quality of the information is questioned. It was also not possible to obtain the same quantity of 'statistical' information from one person to another. In many instances the information was simply not available.

(One complementary comment on both hospital organisations is that whatever the internal problems of communication, very rarely did information from one person conflict with that given by another).

CHECKLIST :

BEST BUY EVALUATION 1978 Date: Time:

Interviewee:

SUBJECT/DEPT :	Attitude/ Satisfaction	Functional Performance	Commentary Statistics/Change
Location of Dept:			
Access/Communications			
Accommodation			
Functional Aspects			
Environmental "			
Maintenance "			
Relationship with other Depts			
Change in other Depts affecting op policy			
Links & Changes with Community Services			
Definition of current catchment area			
Primary Function			
Workload: throughput, occupancy length of stay (Policies group 111)			
; no: of sessions, length, throughput (Policies group IV, V)			
Staffing Levels			
Patient Care: grouping movement (111) reception, domestic (IV, V)			
Visiting or Relatives			
Control of Infection			
Resuscitation Services			
Pharmacy "			
Housekeeping "			
Pathology "			
Dept: Administration			

SUBJECT/DEPT :	Attitude/ Satisfaction	Functional Performance	Commentary Statistics/Change
Legal Requirements			
Other Research/Reports etc			
Central Treatment-Commentary			
Effects caused by Salmon/ NHS Reorganisation			
Other			

MONITORING - CHECKLIST : POLICIES : TAPE -RECORDERS

The checklist attempted to extract from every written policy a number of independent points that more or less coverd the scope of what was written, whilst allowing for variations incurred by departmental development, and by 'external' change - such as new legislation since the commissioning of the hospital.

Additionally it was used to draw out the consistent running-theme and approach common to every written policy. (A checklist is attached). It was used in conjunction with the reading (by the interviewee) of a copy of the original Planning Policy, and commentary was indicated where relevant, and recorded in detail, in hand-written notes and - for a number of interviews - by tape-recorder.

ORGANISATION OF RESULTS

Notes were taken during a visit to every hospital department. Later on reports were written up using the checklists and tape-recordings as aids to the memory.

The points in the checklist were typed in semi-random order and served mainly to show if all appropriate information had been obtained.

It was decided to redistribute the grouping of responses for the purposes of the report and the following pattern has been adopted for the majority of 'sections' concerned with departmental or organisational groupings in each hospital.

ORDER OF THE REPORT

For every section the information is recorded in the following manner:

Identification of the department and/or service:

eg HOUSEKEEPING

Followed by synopsis of the organisation and design as outlined as the Planning Policies :

eg LOCATION AND DESCRIPTION OF DEPARTMENT
and PURPOSE, FUNCTION AND ADMINISTRATION

Following (in alphabetical order) are the results of the interviews and information received by the team written up for BURY ST. EDMUNDS (West Suffolk DGH) and FRIMLEY (Frimley Park DGH) in the following order :

PURPOSE, FUNCTION AND ADMINISTRATION

WORKLOAD AND STAFFING (where appropriate)

ACCOMMODATION

ENVIRONMENT : ENGINEERING

OTHER

Finally at the end of each section a short summary of points is made in 'CONCLUSIONS' which also refer to the relevance and/or departure from the original 'Planning Policies'.

At the end of the Report a major 'CONCLUSION' section attempts to summarise the main points such as the validity, development and change in the design and policies of the departments and hospitals as a whole. Commentary on the effectiveness of this research and subjects considered worthy of further study will also be included.

In general the order of information given will include points from the checklist in the following manner :

SUBJECT :	CONTENT :
Location and Description of Department :	Location of Dept : Access/Communications Accommodation
Purpose, Function and Administration :	Relationship with other Depts. Definition of current catchment area.
	Primary Function Workload: Throughput, occupancy/length of stay (Policies group 111) : no: of sessions, length, throughput (Policies group IV,V) Patient Care: grouping, movement, reception, domestic. Visiting or Relatives Control of Infection Housekeeping
	Dept : Administration
	Legal Requirements Other Research/Reports etc Effects caused by Salmon/ NHS Reorganisation

SUBJECT :	CONTENT :
Workload and Staffing :	Workload: throughput, occupancy/length of stay (Policies group 111) : no: of sessions, length throughput (Policies groups IV,V) Staffing Levels Change in other Depts affecting op policy.
Accommodation :	Accommodation Functional Aspects
Environment/Engineering :	Functional Aspects Environmental " Maintenance "
Other/Conclusions :	Any relevant points, including in particular the following : Primary Function Relationship with other Depts Change in other Depts affecting op policy Links and Changes with Community Services Definition of current catchment area Legal Requirements Other Research/Reports etc Central Treatment-Commentary Pharmacy Pathology Other

Background & general information.

FACILITIES FOR HEALTH : COMMUNITY CARE BURY ST EDMUNDS

HOSPITALS	BEDS	
West Suffolk dgh (Bury St Edmunds)	582	Acute
Thetford Cottage Hospital (Thetford, Norfolk)	Out-Patients	
St Leonards Hospital (Sudbury)	28	Acute
Newmarket General Hospital (Newmarket)	288	Acute
Walnuttree Hospital (Sudbury)	120	Long Stay
Jane Walker Hospital (Colchester, Essex)	171	Mental Handicap
Risbridge Hospital (Haverhill)	239	Mental Handicap
St Marys Hospital (Bury St Edmunds)	Closed (Long stay moved to DGH)	

DAY HOSPITAL	
West Suffolk DGH	Psychiatric
Thetford Cottage Hospital	Geriatric
Newmarket General Hospital	Geriatric
Walnuttree Hospital	Geriatric
St Marys Hospital	Geriatric - now at DGH

HEALTH CENTRES

Woolpit Health Centre (Bury St Edmunds)

Bury St Edmunds Health Centre

HEALTH CLINICS

Sudbury	-	Acton Lane
Haverhill	-	Camps Road
Newmarket	-	Exeter Road
Mildenhall	-	Chestnut Close
Thetford	-	Tanner Street

COMMUNITY FACILITIES UNDER SOCIAL SERVICES AND EDUCATION

District Social Services Offices

Waverney	-	Lowestoft
Forest Heath	-	Bury St Edmunds
St Edmundsbury	-	Bury St Edmunds
Mid Suffolk	-	Stowmarket
Suffolk Coast	-	Woodbridge
Babergh	-	Sudbury
Ipswich	-	Ipswich

Special Schools

Lowestoft	2
Ipswich	4
Bury St Edmunds	2
Sudbury	1
Stowmarket	1

Community Homes

Lowestoft	1
Ipswich	5
Stowmarket	1
Sudbury	1
Bury St Edmunds	1

Adult Training Centres (Mentally Handicapped)

Ipswich	2
Lowestoft	1
Bury St Edmunds	1
Sudbury	1
Saxmundham	1

Reception Centres

Ipswich	1

Occupational and Industrial Centres for the Handicapped

Ipswich (1 voluntary)	2

Working Hostel

Ipswich	1

Voluntary Accommodation for the Mentally Ill

Ipswich	1

Observation and Assessment Centre

Stowmarket	1

Home for the Mentally Infirm

Aldeburgh	1

Community School (Controlled)

Eye	1

Residential Homes for the Elderly

Suffolk	31

Handicapped Childrens Hostels

Ipswich	1
Bury St Edmunds	1

Voluntary Day Centres for the Elderly

Lowestoft	1
Beccles	1

Non Statutory Handicapped Children Homes

Yaxley 1

Day Nurseries

Ipswich - Local Authority 1

- Voluntary 1

Voluntary Handicraft Centres for the Mentally Handicaped

Woodbridge 1

Hostel for Mentally Ill Adults

Bury St Edmunds 1

Hostels for Mentally Handicapped Adults

Lowestoft 1

Bury St Edmunds 1

FACILITIES FOR HEALTH/COMMUNITY CARE — FRIMLEY

HOSPITALS	BEDS	
Frimley Park Hospital, Frimley	579	Acute
Frimley Childrens Central, Frimley		Outpatients
Northfield Hospital, Aldershot	Closed	
Green Lane Hospital, Farnham	Closed	Long Stay
Farnham Hospital, Farnham (Psych) (Geriat)	276	Long Stay
Fleet & District Hospital, Aldershot	34	Long Stay
Brookwood (Psych)	1250	(3 health districts)

HEALTH CENTRES

Farnham Health Centre

Aldershot ' '

Camberley ' '

Yateley ' '

Frimley ' '

Ash Vale (under construction)

SURGERIES

Various approx 150

CLINICS

Cove Manor (dental)

Fleet (dental)

COMMUNITY FACILITIES UNDER SOCIAL SERVICES AND EDUCATION

District Social Services Offices

Elmbridge	- Esher
Epsom and Ewell	- Epsom
Guildford	- Guildford
Mole Valley	- Dorking
Reigate and Banstead	- Reigate
Runnymede	- Egham
Spelthorne	- Ashford
Surrey Heath	- Camberley
Waverley	- Godalming
Woking	- Woking
Basingstoke	- Basingstoke
Andover/Romsey	- Andover
Winchester	- Winchester
Alton/Peterfield	- Alton
Aldershot	- Aldershot

Community Homes

Haslemere	2
Banstead	1
Caterham	1
Leatherhead	1
Camberley	1
Farnham	1
Godalming	3
Guildford	3
Hindhead	2
Woking	2
Staines	1
Horley	1
Egham	1
South Godstone	1

Homes for Mentally Handicapped Children

Woking	2
Epsom	1
Basingstoke	1
Winchester	1

Observation and Assessment Centres

Mitchem	1
Guildford	1
Winchester	4
Romsey	1

Childrens Homes

Newbury	1
Andover	4
Basingstoke	5
Liss	2
Alton	1
Romsey	1
Farnham	1
Odiham	1
Wickham	2
Winchester	3

Day and Residential Nurseries

Epsom	1
Redhill	1
Weybridge	1
Ashford	1
Woking	2
Long Ditton	1
Aldershot	1
Basingstoke	1
Winchester	1

Day Centres for the Elderly

Basingstoke	1

Residential Homes for Adolescents

Redhill	1
Woking	1

Home for the Physically Handicapped

West Molesey	1
In North Hampshire-Division for Blind Elderly and Disabled	24
In Surrey for the Elderly	40

Day Centres for the Physically Handicapped

Staines	1
Fetcham	1
West Molesey	1
Woking	1
Guildford	1
Basingstoke	1

Adult Training Centres (for the Mentally Handicapped)

Banstead	1	Guildford	1
Redhill	1	Aldershot	1
Woking	1	Alton	1
Staines	1	Andover	1
Walton-On-Thames	1	Basingstoke	1

Homes and Hostels for the Mentally Handicapped

Ottershaw	1	Winchester	1
West Molesey	1	Basingstoke	1
Camberley	1	Aldershot	1
Walton-On-Thames	1		

Homes and Day Centres for the Mentally Ill

Woking (Home)	1	Basingstoke	(Home)	8
Epsom (Day Centre)	2	Guildford	(Day Centre)	1

Child Guidance Clinics (Education)

Chertsey	1	Guildford	1
Chipstead	1	Walton-on-Thames	1
Epsom	1	Leatherhead	1
Farnham	1	Redhill	1
Godalming	1	Staines	1
		Woking	1

Special Schools for Deaf and Partially Hearing

Farnborough	1	Ewell	2
Redhill	1	Woking	2
Caterham	1	Basingstoke	1

Delicate Children and Physically Handicapped (Educational)

Oxted	1	Farnham	1
Guildford	1	Bagshot	1

ESN Children

Peterfield	1	Camberley	2
Basingstoke	1	Weybridge	1
Andover	1	Caterham	1
Guildford	3	Merstham	1
Redhill	1	Staines	1
Farnham	2	Shepperton	1
Horley	1	Woking	1
Walton-on-Thames	1	Leatherhead	2

Special Schools and Schools for Maladjusted Children

Alton	1	Dorking	1
Andover	2	Guildford	2
Aldershot	1	Chobham	1
Farnborough	1	Epsom	1
Basingstoke	2		

Day Centres

Windlesham	1	Ashford	1
Reigate	1	Redhill	1
Ewell	1	Guildford	1

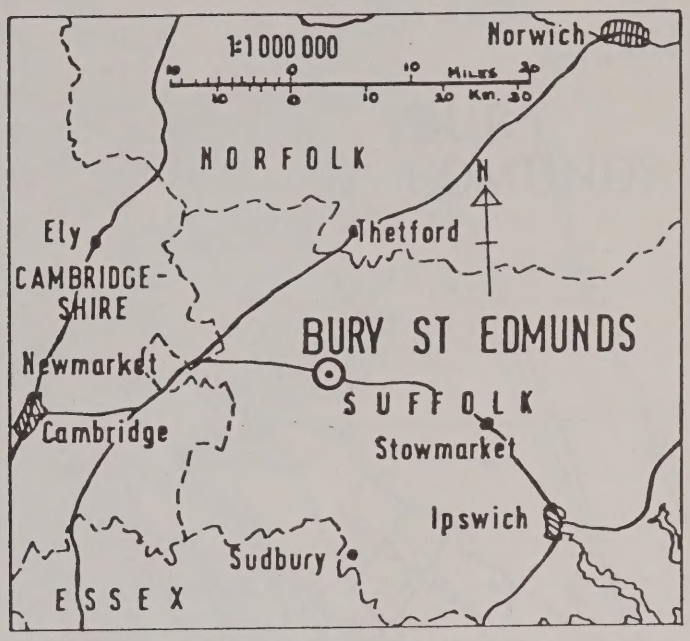
Remedial Centres

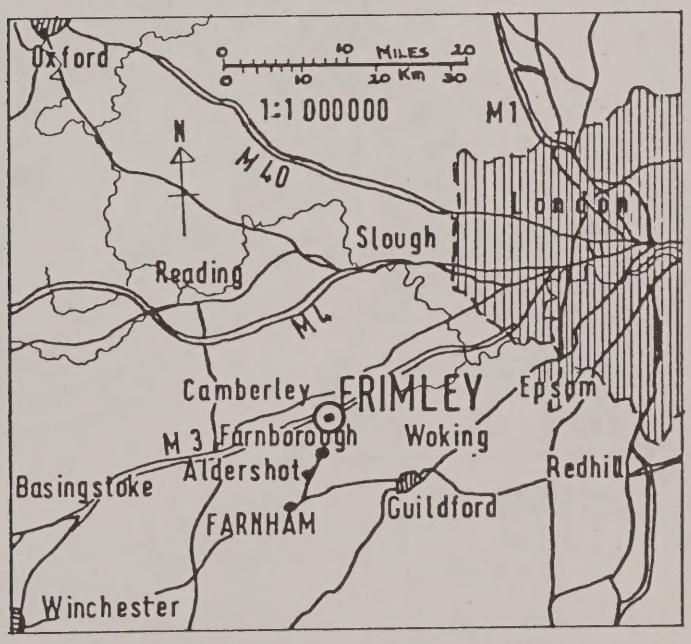
Redhill	1	Guildford	1
Farnham	1	Normandy	1
Woking	1	Ottershaw	1
Caterham	1	Staines	1
Epsom	1	Walton-on-Thames	1
Dorking	1		

Hospital Schools

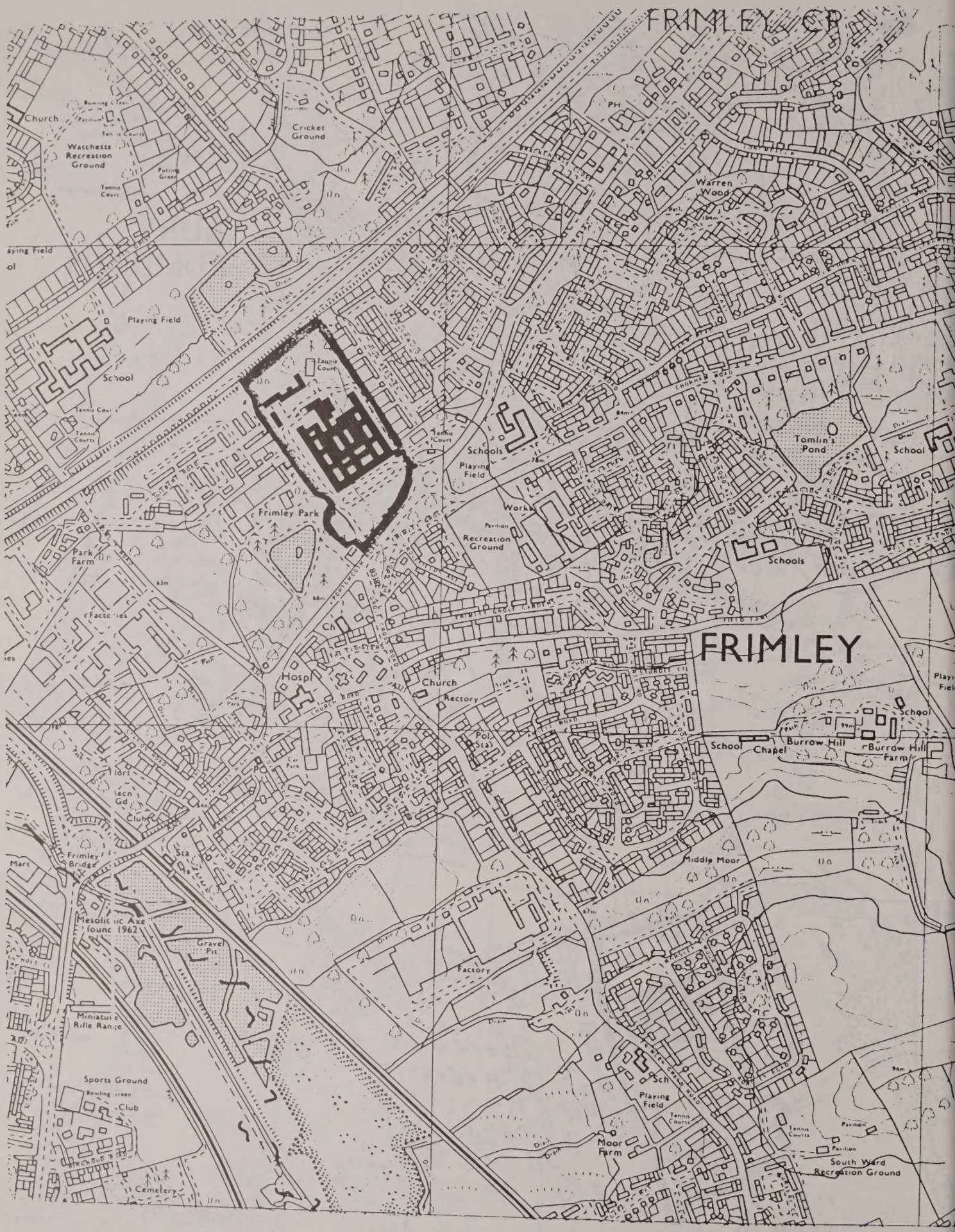
Alton	1	Reigate (ESN)	2
Woking (PH)	1	Epsom (ESN)	1
Tadworth (PH)	1	Redhill (ESN)	1
Epsom (Malaj)	1	Caterham (ESN)	1
Chertsey (ESN)	1	Hook	1

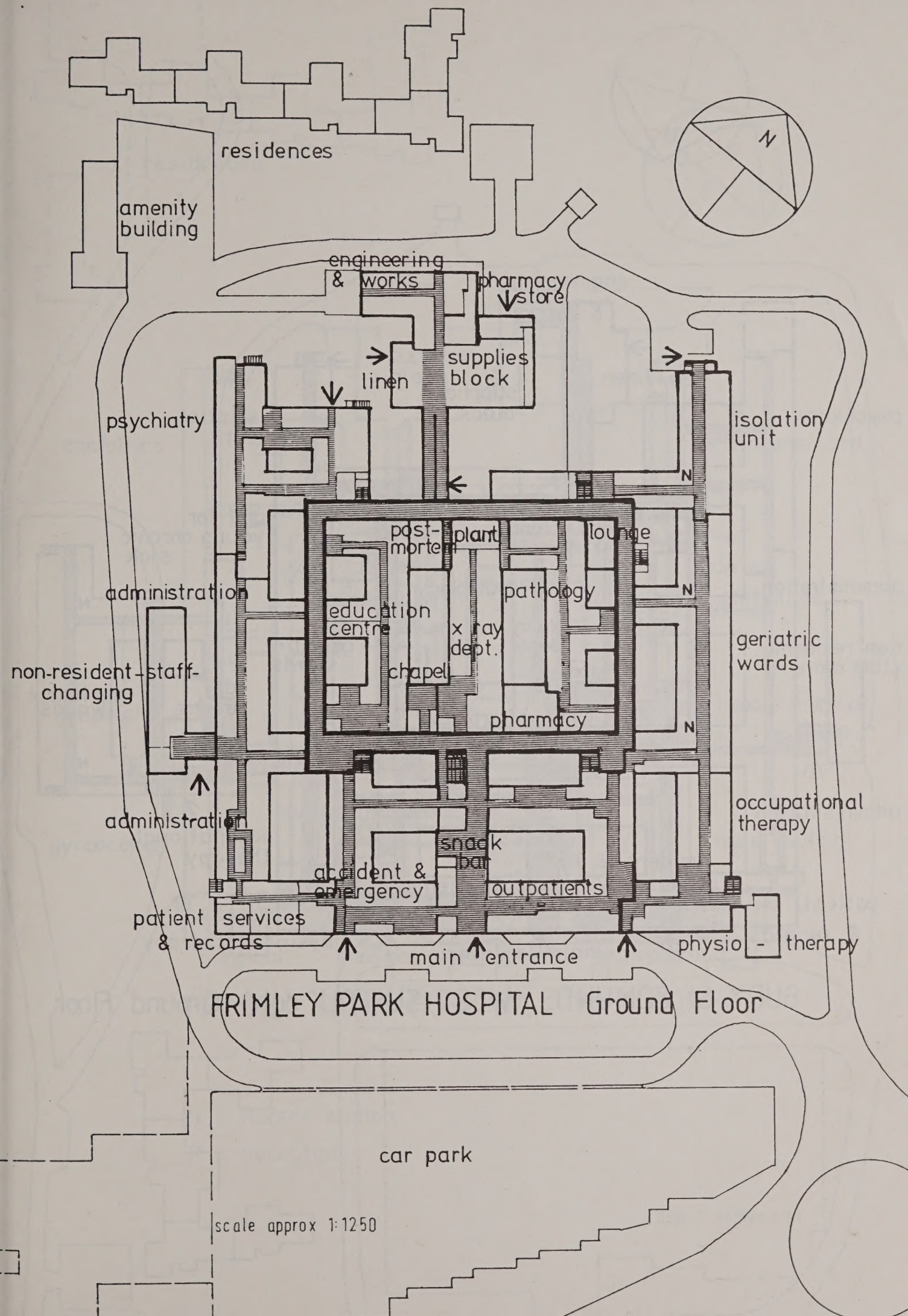
Best Buy Hospitals.





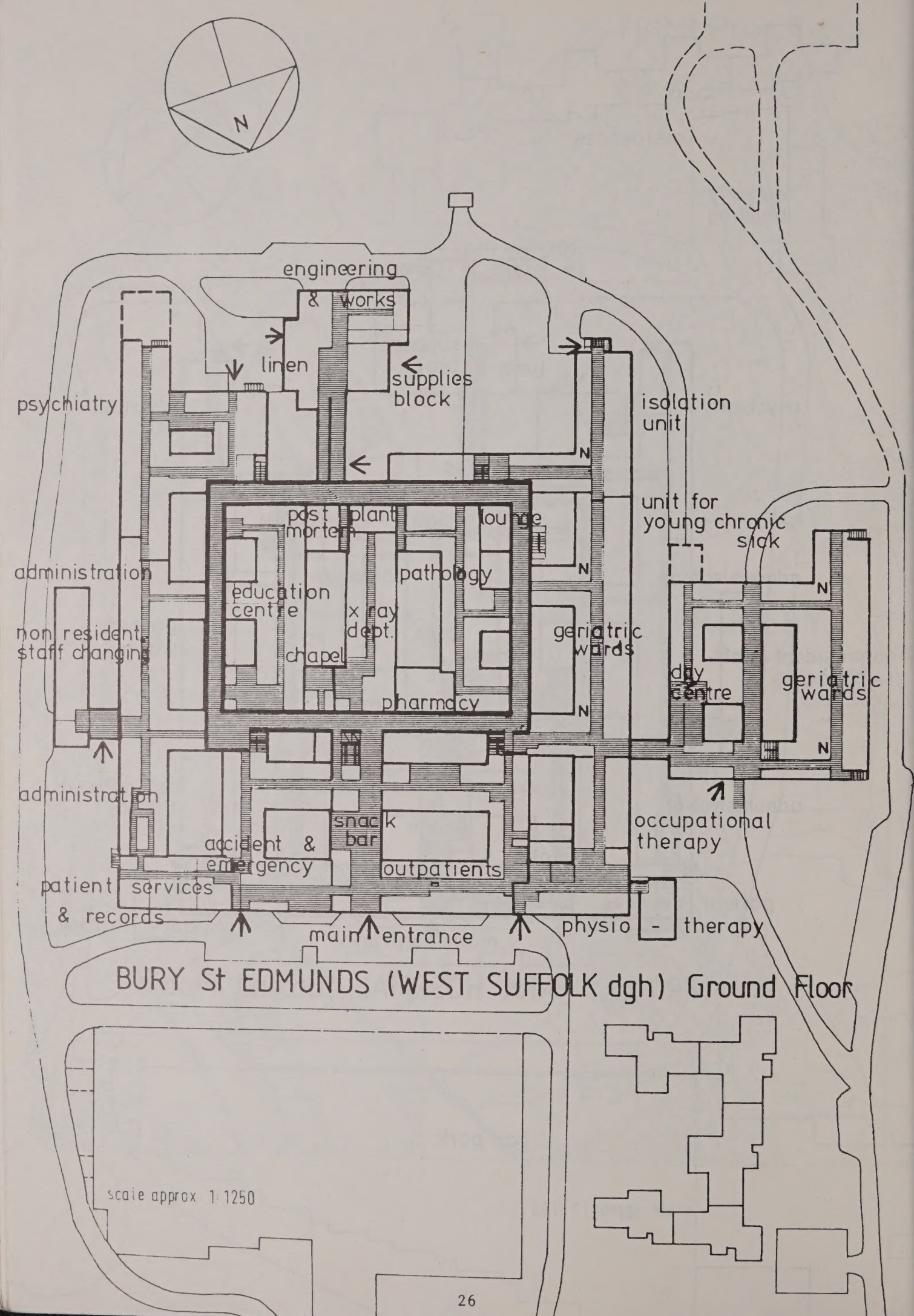
BURY
ST EDMUNDS
School
Allotment Gardens
Grange Farm
Hospital
The Glen
Jocelyn's Buildings
Clay Cottages
Chapel
Eastgate Bridge
Walnut Tree Close
Abbey Garden
Remains of Abbey Church
(Benedictine Founded A.D. 1020)
Abbey Ho.
Grammar School
Dairy
Hall
Sunfields Farm
Shakers Lane
Dove Fields
CATTLE MARKET
Baths
Town Hall
Drill Hall
Works
ST JAMES CATHEDRAL
Vicarage
Chapel
Church
The Cranks
BIRKE HALL
War Meml
Allot Gdns
St Andrew's Castle
St Mary's Hospital
Hospl
School
Infmy
Chapel
R.C. Ch
No Man's Meadows
St Botolph's Bridge
School & Mission Room
River Linnet
Spread Eagle (P.H.)
Stamford Bridge
Holywater Meadows
Great Sexton's Meadows
Mayne Water
Gravel Pit
The Vinery
York Bridge
The Grundle
Southgate House
Holywell Cottages
Almoner's Barn
STONEBRIDGE AVENUE
Laundry
Southend House
The Fort
Allot Gdns
Parva Cottage
Isolation Hospital
Sports Ground
Pavilion
South Lee
Victory Lodge
Porteus Co
Hardwick Heath
Lodge
Dairy Cottage

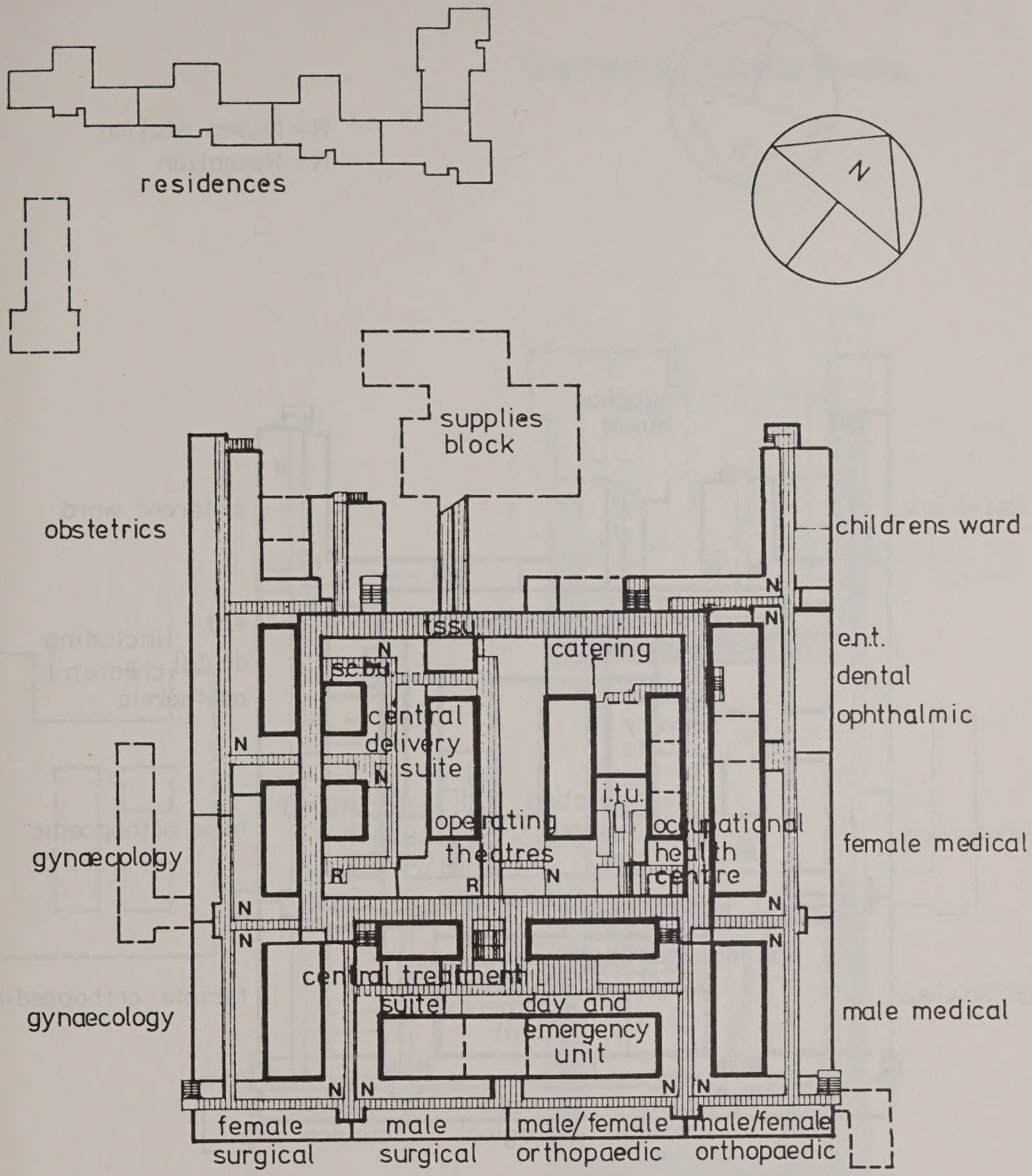

FRIMLEY CP
FRIMLEY
Church
Watchetts Recreation Ground
Cricket Ground
PH
Warren Wood
Playing Field
School
Tennis Court
Tennis Courts
Schools
Playing Field
Tomlin's Pond
School
Frimley Park
Works
Recreation Ground
Schools
Park Farm
Factories
Hospl
Church
Rectory
School
Chapel
Burrow Hill
Burrow Hill Farm
Club
Frimley Bridge
Middle Moor
Mesolithic Axe found 1962
Gravel Pit
Factory
Miniature Rifle Range
Sports Ground
Club
Playing Field
Moor Farm
South Ward Recreation Ground
Cemetery



FRIMLEY PARK HOSPITAL Ground Floor

scale approx 1:1250

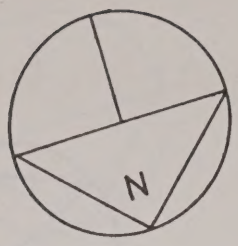

N
engineering & works
linen
supplies block
psychiatry
isolation unit
post mortem
plant
lounge
unit for young chronic sick
administration
pathology
education centre
x ray dept.
non resident staff changing
chapel
geriatric wards
day centre
geriatric wards
pharmacy
administration
snack bar
occupational therapy
accident & emergency
outpatients
patient services & records
physio - therapy
main entrance
BURY St EDMUNDS (WEST SUFFOLK dgh) Ground Floor
scale approx 1:1250



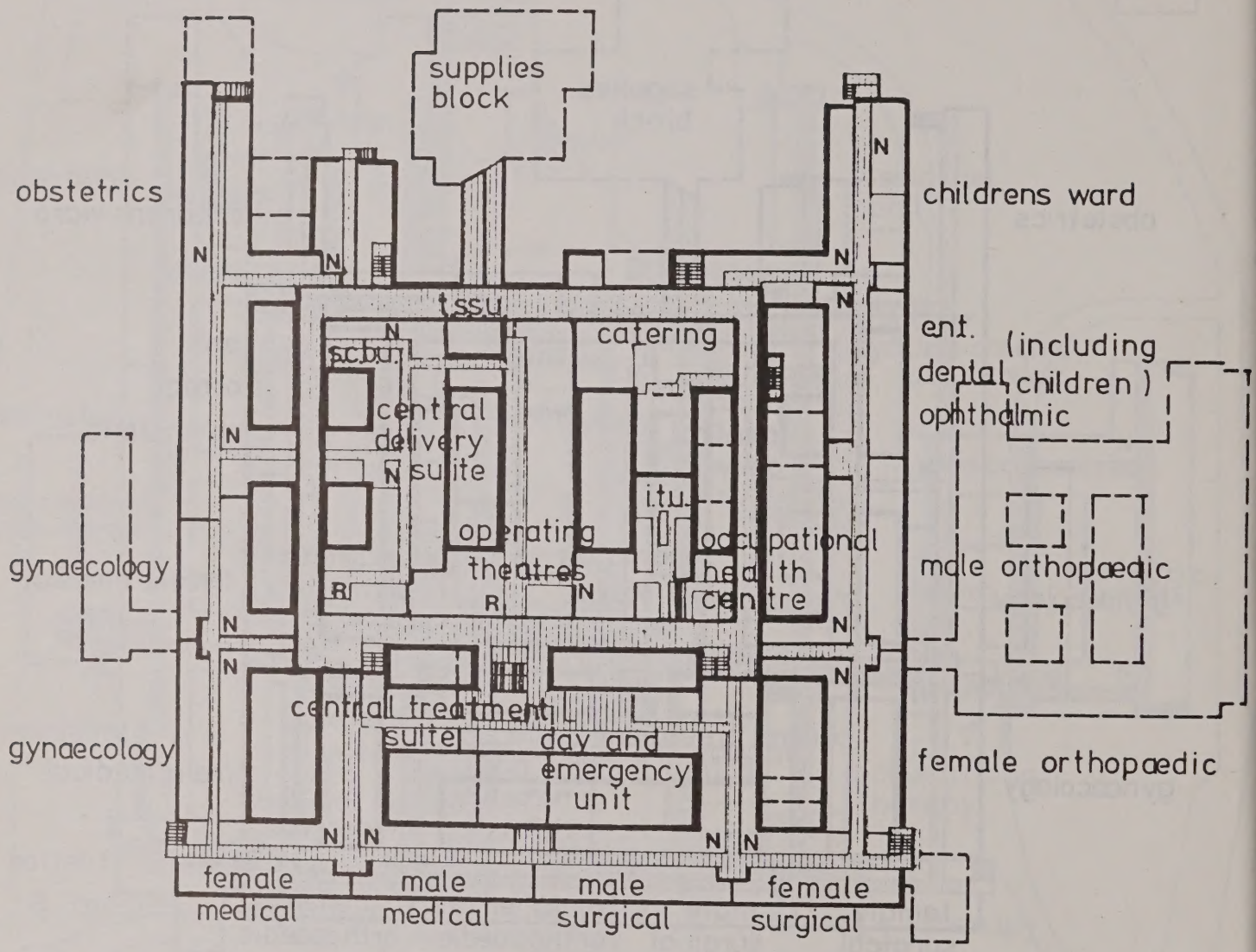
FRIMLEY PARK HOSPITAL 1st FLOOR

N = Nurses station

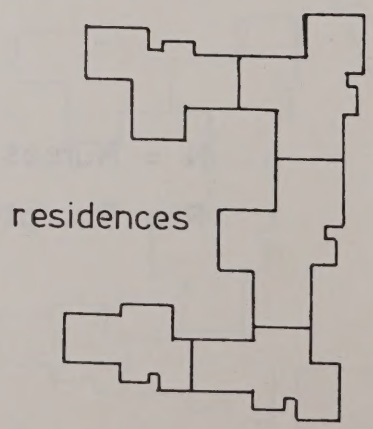
R = Reception



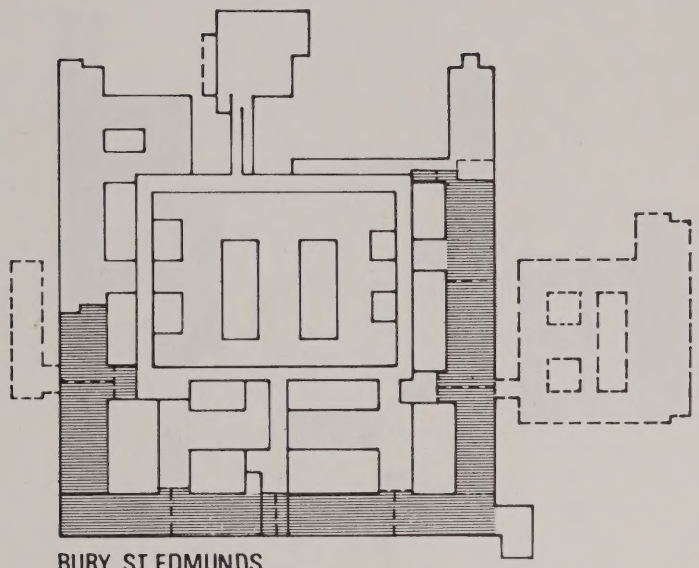
N = Nurses station
R = Reception



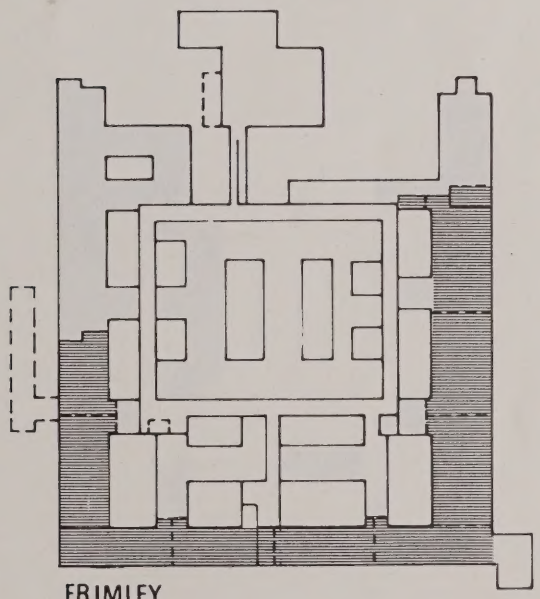
BURY St. EDMUNDS (w.s.d.g.h.) 1st FLOOR



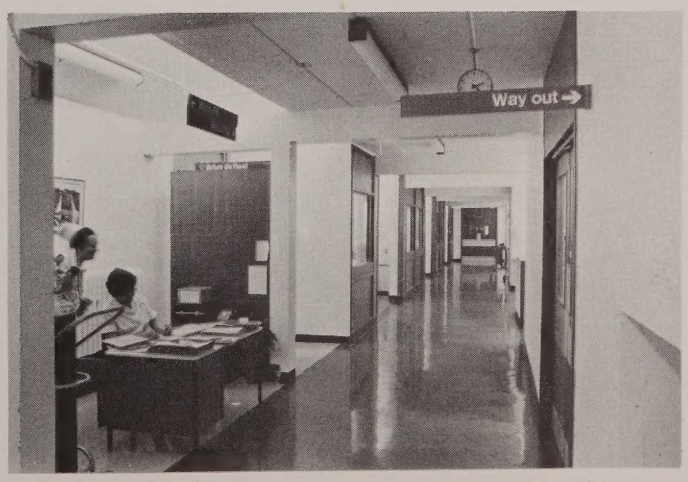
General Acute Beds.



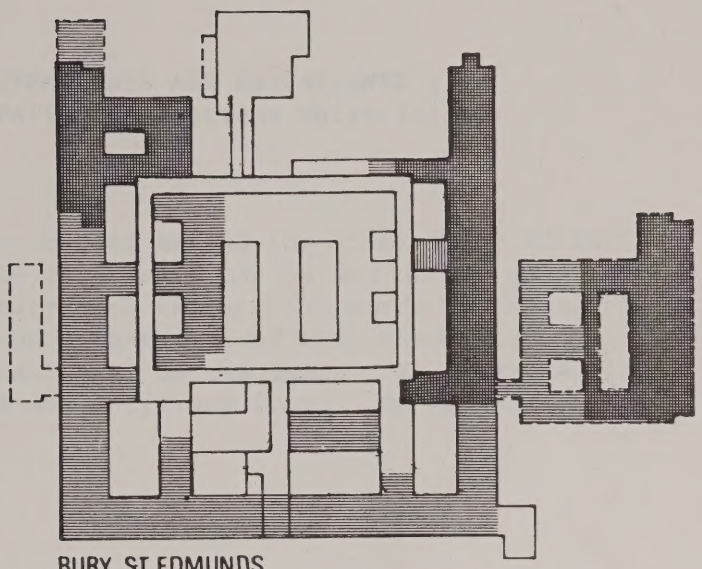
BURY ST EDMUNDS



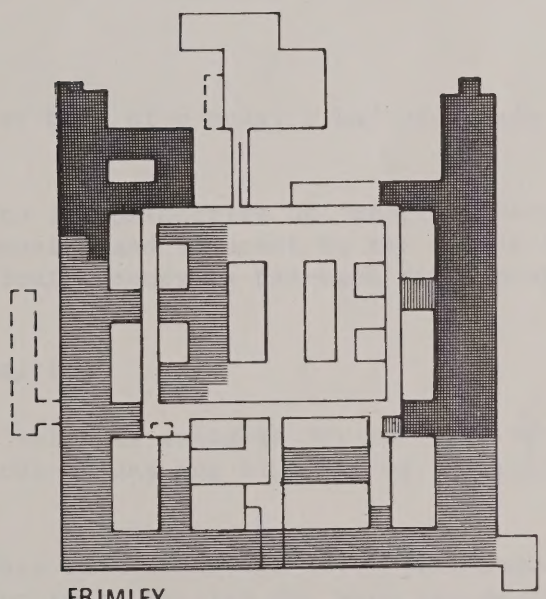
FRIMLEY



Acute inpatients- adults & children, obstetric, psychiatric, & geriatric services.



BURY ST EDMUNDS



FRIMLEY

INPATIENTS: GENERAL ACUTE BEDS

This section includes:

ENT/Dental/Ophthalmic Beds
Orthopaedic Beds
Medical Beds - general
Surgical Beds
Gynaecology Beds

For Day and Emergency Beds refer to 'OUTPATIENTS AND DAYPATIENTS'; for other specialties refer to the 'INPATIENTS' sections which follow.

LOCATION AND DESCRIPTION

The general acute wards are peripherally banded around the first floor of the hospital. They are designed to a common pattern of use by any of the above specialties, and by either sex. Link corridors connect the wards to the main 'street' and contain ancillary rooms. On either side of this connecting link in the wards are situated the nurses stations. On the inner side of the wards, overlooking courtyards are single rooms and ancillary rooms. On the outer side are 6 or 8 bed bays.

304 beds are available.

There are:

5 sections of 36 beds
2 sections of 35 beds
1 section of 33 beds
1 section of 21 beds

Each 36 bed section is divided into four bays of 6 beds, 1 bay of 8 beds, and 4 single rooms.

Patients were to be grouped according to the principles of 'progressive-patient-care' with high dependency patients opposite and adjacent to the nurses station, and intermediate to low dependency patients occupying bed-bays sited progressively further away.

PURPOSE, FUNCTION, SCOPE, AND ADMINISTRATION

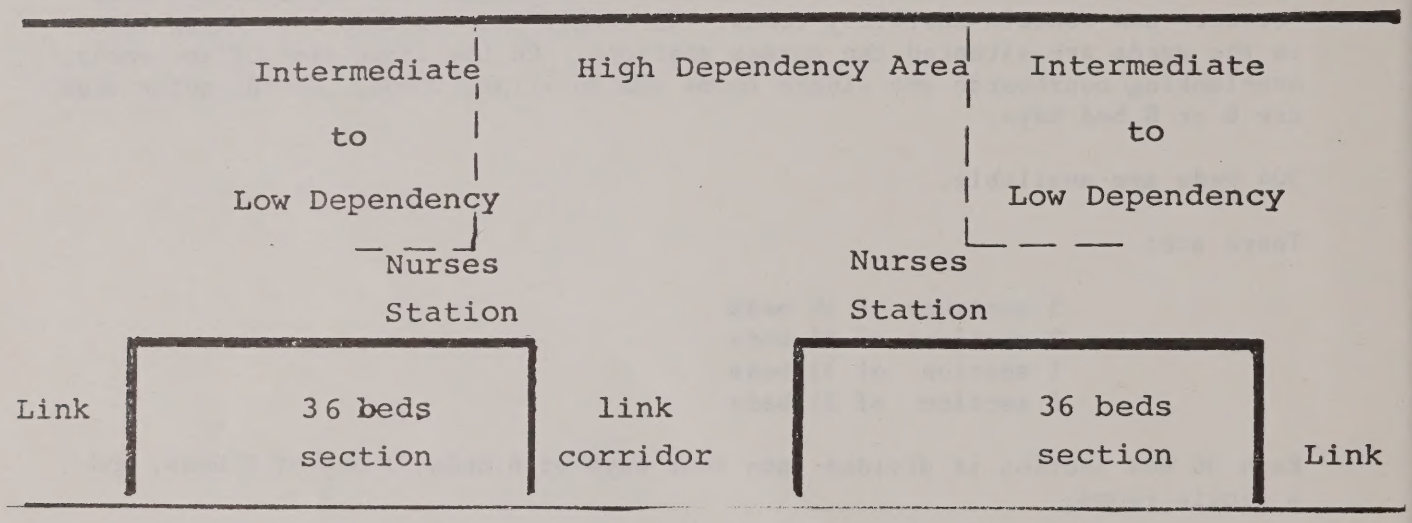
The aim was to provide an environment 'which is suitable for the care of the patient according to his particular needs at any one time during the course of his illness'.

The objectives were to 'keep the patients in a condition which will enable diagnosis, treatment, and rehabilitation to be carried out with the minimum distress, embarrassment or pain, and with the maximum economy and speed'.

Anticipating national trends and government guidance, at the time of planning the hospitals were designed to accommodate general acute beds in the ratio of 2/1000 population.

'Progressive-patient-care' was to be practised within a section of 36 beds. High dependency zones for each pair of sections are contiguous for flexible use.

About 1/3 of patients were expected to require 'heavy' or 'technical' nursing care. Nursing would be on a team basis within the section and high dependency patients would be placed between two sections to ensure easier night-cover.



A majority of treatments were to be carried out in the Central Treatment Suite, but a 'percentage of treatments requiring aseptic techniques will invariably be carried out at the patients bedside, and in single rooms'. Other treatments might be carried out in the assisted bathrooms.

A charge nurse/sister would be responsible for the management of each section and would be supported by an appropriate nursing establishment and in non-nursing duties by the housekeeping and portering staff.

ENT; Dental: Ophthalmic beds were included in the general inpatients policy statement, but were not specifically detailed. Administratively they come under different control although functionally they are included in general inpatients. This is not satisfactory.

Detailed notes are included in the CONCLUSIONS to this section.

PURPOSE, FUNCTION AND ADMINISTRATION

'Patients like the wards and the 6-bed bays - though some miss the old wards'. The adjacency of two wards (72 beds) is ideal, allowing for flexibility between the wards for staffing purposes, sharing of expensive equipment, good use of beds, and when dealing with a crisis. At night this is appreciated although the length of the darkened wards causes some dissatisfaction. Medical staff also appreciate linked wards.

Progressive-patient-care is practised as in the policies, but it is thought that more patients are highly dependent than was originally suggested. Team-nursing is encouraged: 3 teams are required for such a ward size (often only 2 are available). The policy as written is strictly adhered to and is explained to new staff.

The use of the Day and Emergency Ward between 6pm and 8.30am is particularly appreciated by the patients 'who get disturbed much less than when they were in the old wards.'

The Central Treatment Suite is much appreciated by ward staff, although it requires considerable organisation and training ... 'It is very valuable ... we would not be without it'.

ADMINISTRATION

There is:

1 Nursing Officer for	F5 Surgical	(F)	= 35 beds
	F6 Surgical	(M)	= 36 beds
	F4 Orthopaedic	(F)	= 34 beds
	F3 Orthopaedic	(M)	= 28 beds
	D & E beds		= 18 in use
	Central Treatment		
1 Nursing Officer for	F7 Medical	(M)	= 36 beds
	F8 Medical	(F)	= 35 beds
	F9 Medical and Gynaecology		= 29 beds
	F10 Gynaecology		=(21 empty)
	ITU/Coronary Care		

WORKLOAD

The following figures were obtained from 1976 Statistics.

	Gen Medical	Surgical	Gynaecology
Length of stay (days)	12.6	8.0	5.8
AV daily occupancy (%)	58.2	65.5	20.7
AV available commissioned beds (%)	73.3.	79.6	30.0

STAFFING	CURRENT	POLICY
Nursing	1 sister/ward plus 1 relief for 2 wards (as in Policy)	
	2 staff nurses	3
	1 part-time staff nurse	-
	7 student nurses	5.5
	2 pupil nurses	2
	1 full-time nurse auxiliary	2.5
	1 part-time nurse auxiliary	-

This amounts to 11.6 for day-duty, and 2-3 each night.

Housekeeping:

The housekeepers are an important part of the ward teams, and the policy has been adhered to. The section-housekeeper does a lot of clerical work. The fact that administratively the Housekeeping Service is not under the control of the ward sister is causing difficulties: certain duties such as the serving of food are considered to be satisfactory for housekeeping staff, but nurses consider that it is an essential part of nursing to see what the patient eats and leaves. A typical (required) housekeeping staff for a ward would be:

1 section housekeeper
2 housekeepers
1/2 housekeeping aides

Full Housekeeping is available on the following wards:
G2, G3, G4, F4, F5, F6, F7, F8.

ACCOMMODATION: DEVELOPMENT AND CHANGE

The size of the wards is considered to be too large and the number of beds/ward should be reduced to a maximum of 30 beds.

At first the multi-bed bays appeared to be difficult to work in amongst very sick patients, but after two or three years of experience the nurses seem satisfied and seldom complain. Even with orthopaedic patients in traction, the space is just adequate.

The 8-bed bays can be used for 'self-care patients' in the surgical wards, but they are impossible for orthopaedic patients, and in the medical wards they are exceedingly cramped - there are too many sick patients to enable them to be used for 'self-care' patients. Also cardiac-arrest procedures are practically impossible to carry out in such space. In two wards, 2 beds have been removed from the 8-bed bays and in another the 8-bed bay is used for storage (much needed). The Staff were not funded for more than 30 beds/ward.

Male and female patients can be nursed in adjacent bays without any complications because there are sufficiently well-sited WC and bathing facilities. The availability of single rooms is occasionally at a premium and this leads to admission of patients onto other wards. The bed bays are liked by the patients who use the integral sitting areas for much of the time: but in orthopaedic wards where there is a large percentage of older people, and greater risks of accidents, it is often impossible to see the patients. A complete staff establishment would compensate for this.

Sanitary Facilities:

These are satisfactory and sufficient in number not to cause any hold-ups. Bidets are liked but seldom used.

Treatment Bathroom:

This is used a lot. Often 2 patients are treated at one time, this has been made possible by moving the curtains. The shower fitment from the bath to the basin is particularly appreciated. The WC with a hatch to dirty-utility is a particularly useful feature, and the siting of dirty-utility to the staffbase is considered good - but noise from the bed-pan disposal machines is excessive at night so the bed-pans pile up for disposal in the morning. The showers are considered too small for orthopaedic patients.

Supplies Area:

This is generally adequate, although more cupboards would be useful, particularly as there is a security problem about loss of materials etc. Both supply and disposal rooms are used as passage-ways.

Beverages:

The staff-base point for kettles and milk heaters and the water-boiler in the corridor seem to be adequate, as the kitchens will send snacks and diets whenever required.

Staff-base (nurses-station):

It functions reasonably well, but staff would have preferred it further down the ward, because of the accident rate of patients. It is a very noisy area and patients can overhear staff reporting. It is possible to observe 8-9 beds directly from this base (this accords with the policy), but it is felt to be too low a number.

Sisters Office:

This is situated in the link corridor and is not much used, except for changing into uniforms.

Examination Room:

This is not much used except in the gynaecology wards.

Staff Cloakroom:

The staff prefer changing at ward-level, and the areas are large enough for a lot of non-resident staff to change.

ENVIRONMENT AND ENGINEERING

1 Courtyards are much appreciated by the patients.

2 The control of temperature in the wards has been a problem, and the radiators are a hazard when they are too hot.

3 The oxygen and suction points are provided for 10 beds in each ward. In the surgical wards more suction points are needed and in the medical wards

more oxygen points. Full flexibility in use of beds is not possible, and the mobile cylinders are always being used.

4 Night-lighting in the corridors (ward level) is urgently required.

5 Linked system of communication between two wards is a problem and requires further study. 'Muting' which is possible and is suggested in the policies is not acceptable as a nurse in a bay or room cannot hear the call. The 'noisy' call would be preferable.

6 The bed pan disposal units are constantly out of order and are too noisy to use at night. Slop-hoppers would have relieved this situation.

7 The wearing of wall fabric at the ward-entrances (particularly from trolleys and cylinders) makes the appearance 'slum-like'.

8 The wooden panels above all lavatory basins are badly worn, and protection is required.

OTHER

Control of Infection:

The introduction of the Central Treatment Rooms is thought to have contributed to a low infection rate, as has the ability to move patients to Isolation Ward when required.

Visiting:

This no longer occurs all day. Patients are said to prefer set hours (3.30 pm - 5.30 pm and 7.00 pm - 8.00 pm), but there is flexibility for those who find it difficult to reach the hospital within those times.

Pharmacy Products:

At present drugs are in the same refrigerator as patients' food and milk. An additional refrigerator is required.

Movement of Patients:

The movement of patients in Kings Fund beds is carried out according to the policy and is well liked.

Community liaison and NHS/'Salmon' reorganisation:

The involvement of nursing officers from the start of commissioning has been invaluable. It is doubtful whether in many instances the policies could have worked without the initiative of these people. The co-ordination of so many people and the introduction of a new pattern of care is exceedingly difficult and one sees the role of the nursing-officer at its best.

Liaison with the community for short-stay schemes is excellent, and reorganisation has helped with such co-ordination as is necessary.

PURPOSE, FUNCTION, AND ADMINISTRATION

Patients generally like the wards, and the adjacency of two wards is valuable in allowing flexibility of use: the staff are able to help each other paticularly at night and in emergencies. The wards meet the needs of the patients. 'Progressive patient-care' is practised but there are more high dependency patients than originally planned for.
The ITU. is often full so a lot of monitoring on medical patients is done on the ward (differing from the policy), 95% of admissions to ITU are emergencies and therefore the 3 booked admissions/day policy has been used more as a guideline ---' it is not stuck to too rigidly. Policy is varied to suit the individual.'

In some wards occasionally, and in two nearly always, the policy has been changed and whole bays are taken over for male or female patients-thus creating a mixed ward. This was essential in reducing the shortage of beds, and the requirements for in-patient accommodation are so high that it still does not allow sufficient flexibility. One of the reasons is thought to be the provision of only 4 single rooms/36 bed ward-section.
Team-nursing is practised as in the policy (2 teams/ward).

The Central Treatment rooms were not much used at first but they are now well liked. The policy of admitting patients to the Day and Emergency Ward at night is not always followed. It depends upon who is on duty in the Accident and Emergency department.

ADMINISTRATION

There is:

1 Nursing Officer for	F3 Medical	(mixed)	
	F4 Medical	(mixed)	
	G1 Isolation		
1 Nursing Officer for	F7 Surgical	(M)	= 35 beds
	F8 Surgical	(F)	= 36 beds
	F5 Orthopaedic	(F)	=
	F6 Orthopaedic	(M)	=
	F2 ENT/Dental/ Ophthalmic	(mixed)	= 25 beds

A 'swing unit' has been created between the ENT/Ophthalmic ward (F2) and the medical ward (F3), by using a 6 - bed bay as such.

WORKLOAD

There is (provisionally) a stated 92% occupancy of beds in the whole hospital.

The Workload is divided as follows:

	Gen Medical	Surgical	Gynaecology
Length of stay (days)	8.2	6.5	5.5
AV daily occupancy (%)	57.1	72.6	37.0
AV available commissioned beds(%)	64.2	87.0	52.1

STAFFING

Detailed breakdown was not given, but for every ward there are 2 sisters, and a total nursing team of 17. Auxiliaries are found to be very useful, and necessary because of the cut-back in students available (owing to education changes).

Housekeeping:

There is usually a team of 4 to each ward, although this is not always sufficient. Nursing Officers would prefer a ward clerk as there are so many admissions to deal with. The housekeeping team not being under control of the ward sister does create some problems.

There is a full housekeeping service for the whole hospital: for details refer to HOUSEKEEPING.

ACCOMMODATION: DEVELOPMENT AND CHANGE

The 36 - bed sized ward is considered far too large. 6 - bed bays are satisfactory and the patients generally like them, but the 8 - bed bay is too cramped and is disliked intensely. As there is no young chronic sick unit in the area, these patients are cared for in the 8 - bed bays in the wards (mainly patients who don't get up much, but have a lot of apparatus around).
The medical wards are mixed, males in one bay, females in another. This works well and the provision of sufficient WC/toilet facilities facilitates the flexible allocation of bed-bays. It is felt that there are insufficient single rooms.

Sanitary Facilities:

The width of WC doors is said to be unsuitable for wheelchairs (contrary to policy), and they are rather heavy for patients to operate independently. The treatment bathroom is necessary, and well used, but it is lacking in grabrails.

Day Spaces:

The 6-bed bay day spaces are used, but are considered small - radiators take up space in them and the heat is difficult to control. In the shared day areas the television and drifting cigarette smoke disturb other patients, and although the nurses don't like leaving patients unobserved it would have been better to provide the day-rooms with doors.

Storage:

This is felt to be a lack of general storage, necessitating the acquisition of several of the housekeepers rooms in the link corridors.

Beverages: Catering:

The bay in the corridor tends to look untidy and is difficult to keep clean. There seems to be no area allowed for making snacks.

Staff base: Nurses Station:

This is inset too far back, and the view of patient call lights is obscured, which is particularly worrying at nights. There is little space between the chair and the drug cupboards. Confidentiality for reports and telephone conversations is difficult as patients can overhear everything, and the area is naturally noisy.

Offices:

The sisters and doctors offices are not used much, neither is the seminar room. Some of these rooms are now being used by consultants.

Changes in room-function have occurred in the following instances:

1) ECG technicians use a housekeepers room.
2) An examination room is used for ECG technicians.
3) Seminar-rooms are used by consultant physicians.
4) The housekeeper/cleaners room is now an equipment store.
5) The housekeeper/receptionist is now sited in the entrance area between 2 sections, and not in the link corridor where communications are poor.

ENVIRONMENT/ENGINEERING

1. The Courtyards are much appreciated.
2. Control of temperature in the wards is a problem.
3. Many more oxygen points are required.
4. Lighting: 1 Clerestorey windows in certain positions have caused problems of glare and solar gain.

   2 Night lighting has been a considerable problem on the wards, with nurses looking into complete darkness, and not being able to see or hear patients beyond the 2nd bay. This is now being rectified.
5. Telephones are required at the housekeepers base. The ones that have been installed are rather shrill, and as a result have been muted and cannot now be heard.
6. The maintenance of bed-pan disposal units has been a continuous problem as they are constantly blocking and seeping. They are also too noisy.

OTHER

Control of infection:

The availability of the Isolation Ward, and Central Treatment Suite has been found very useful and has apparently aided control of infection.

Visiting:

The open-hours visiting has not been found satisfactory.

Movement of Patients:

The movement of patients in their 'Kings Fund' beds is liked and has no problems.

Community liaison and NHS/'Salmon' reorganisation:

There is excellent community liaison which is allowing short lengths of stay to be followed satisfactorily.
A liaison sister visits the wards in order to discuss with the patients their treatment and the facilities of the hospital and 'outside'.
The introduction of nursing officers has probably been the only way of integrating the staff from the surrounding smaller hospitals, and initiating new policies.

Note: Because no detailed policies were written on the ENT/Dental/Ophthalmic beds, general commentary and feedback obtained from the research has been added here.

ENT, DENTAL AND OPHTHALMIC WARD

The policy for this ward was included with the general in-patient wards; as a result there was no detailed operational policy available. This is of interest because if both specialties and their needs had been looked at, it is most likely that a different design would have been devised within the Standard Shape. The ward originally was intended to contain 37 beds, 4 of them in the swing-unit between the Paediatric Ward and this Ward, so that children could be cared for in it without being disturbed by, or disturbing adult patients. In fact this 4-bed swing-unit at Bury St Edmunds is used for visitors or for storage, and at Frimley is found very useful for children who might, for example, all be waiting for ENT operations on the same day.
Children, males and females (ophthalmic etc) are looked after in the F2 ward at Bury, as the consultant considers that they should be kept together under skilled ophthalmic trained staff, rather than be split up; at Frimley children are either in the Paediatric Ward or in the swing-unit.
Flexibility in the use of beds is possible. The ward accommodates mixed speciality use but there are no low-dependency patients so a high technical level of nursing care and control of infection is essential.

Cross infection:

Extreme care is taken to prevent this by keeping eye patients away from ENT patients; medical cases who do not need surgery are placed in between, in the middle of the ward. Although it is recognised as bad clinical practice prophylactic antibiotics are given ... 'we are forced to do this rather than lose an eye'.

Ophthalmic beds:

The bays used by ophthalmic patients are darkened as it has been necessary to obtain the low lighting conditions for first and subsequent dressings. This procedure was never anticipated in the policies or in the design.
An examination cubicle is required on the ward, as the room being used in link corridor is unsatisfactory. It has also proved unsatisfactory taking patients long-distances to use the equipment in the out-patients department (the equipment was not available at ward level).

Nurses station: Observation:

The ward was planned with one nurses station only; it would have been more satisfactory to have two in order to have ophthalmic patients in a darkened area, observable at one end, and ENT patients separately observable at the other.

Community contact: Waiting Lists:

Liaison with the community is excellent and every effort is made to cut the length of stay of patients, (for example, by swabs for intra-oscular surgery

being taken by the District Nurse instead of when the patient comes into hospital). In spite of this the waiting-list at Bury increases at the rate of 20 patients/month, partly because beds at Newmarket have closed, and partly because Addenbrooks (Cambridge) now have a year's waiting-list. Another session in the Operating Theatres would help, but would prove very difficult to fitin.

Conclusion:

The specific needs of ophthalmic and ENT patients should be assessed so that they can be met more satisfactorily.

GENERAL CONCLUSIONS

It seems appropriate at this juncture to say something of the impact of NHS reorganisation, the changes in nursing administration and the changing technical skills and requirements being introduced in education for nurses. These factors in particular are responsible for changing roles at ward-level in how and where patients are treated, observed and cared-for, and the 'Best-Buy' hospitals have provided innovations in design - such as contiguous wards and swing units, Central Treatment and Day and Emergency 'holding' facilities - in which this changing nursing pattern should be able to take place. Housekeepers and porters would assist and in some cases take over non-nursing duties, leaving the nurses free to develop the high-intermediate-low dependency distribution of patient care (progressive patient care), which would correspond to the use of the single rooms and the 6 bed bays respectively. The nursing and other managerial hierachies have reacted to these policies and the planning with a considerable degree of variance.

PHILOSOPHY AND ACCOMMODATION OF 'Progressive-Patient-Care'

It is obvious, even from such a short study, that great differences between policy estimates of population growth and demand for care, have arisen. Particularly, Frimley Park hospital is reaching the stage where policies on admission and care are beginning to necessitate change which could only be accommodated by government aid in the acquisition of more land and the funding of additional beds.
The research-team could not tell whether sufficient statistical evidence was available for such an exercise, but it is believed that more accurate data is now available than in 1968-1970.
The length of stay is shorter in both hospitals than was envisaged, and a large number of patients are high-dependency rather than intermediate to low. Therefore, designing for the stated pattern-of-care was probably wrong, and it has led to lack of flexibility in the wards and a greatly increased staff workload.
The introduction of the ITU and the Day and Emergency admissions during the night has resulted in less need for progressive patient-care within the ward. The real progression in patient care occurs between hospital and community, both before admission and after discharge of patients.

Ward Design:

The wards meet the primary function satisfactorily and are sufficiently well provided with ancillary facilities to allow men, women and children to be accommodated in one ward without embarrassment or inconvenience.
The placing of all surgical wards on the Theatre-floor and the sharing of ward access (one link corridor to 2 x 36 bed wards) seems to be a success, and is well liked by all staff; however, the size of the ward (36 beds) is regarded as being too large.

Many more patients require high dependency care than was envisaged, and observation from the nurses station has been a problem.
The 8-bed bays have insufficient space and are a handicap to proper nursing care. It has been difficult to withdraw 2 beds here because it would mean reducing the number of beds available to certain consultants.

Hospital Policies:

Policies have been followed very carefully with success in most instances. In particular the use of the Central Treatment rooms is appreciated and is considered an essential feature of the hospital. Some treatment rooms for specialties are still required, however. The peripheral banding of the wards could allow flexibility and change of function, although not all staff favour the piecemeal overlapping that occurs, as management difficulties arise. Part of the problem has been created by the introduction of fire-doors (at a late stage) which militate against the philosophy of flexibility.

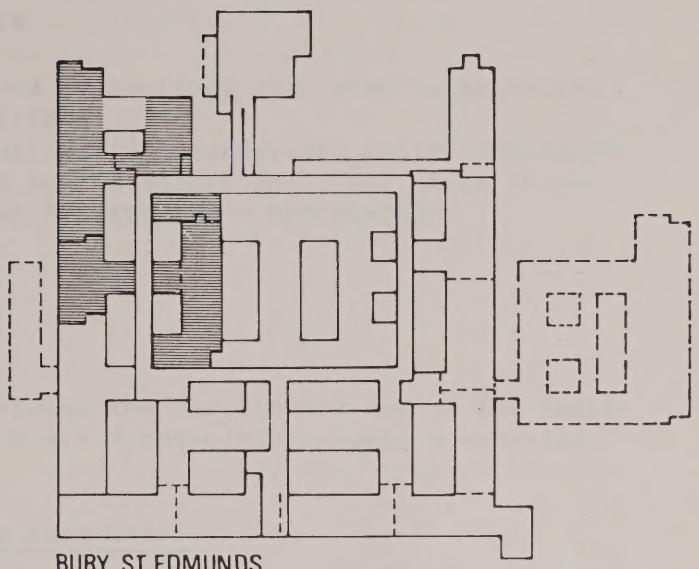
Cost Saving Design:

The design of the wards meets the hospital objectives but at the expense of unsatisfactory bed-spacing in some instances. Storage problems have arisen (in one case necessitating the use of a bed-bay for such) probably due to the lack of foresight on the increased use of equipment, and lighting design for observation at night has been particularly poor. The latter could easily be rectified by slightly changing the design of partitions and by providing suitable low level internal corridor lighting. Adequate nurse management and observation would be achieved by providing full establishment numbers.

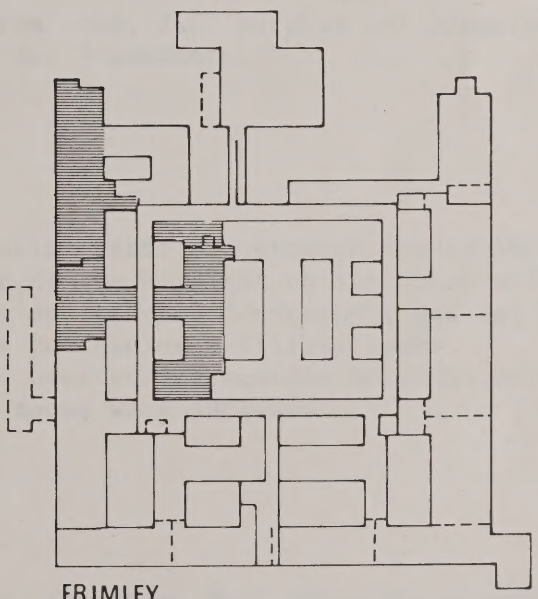
PLANNING: COMMISSIONING POLICIES

The planning policies which were translated into commissioning documents have been invaluable for introducing new staff to their role in the whole hospital, and they have greatly facilitated research and evaluation.

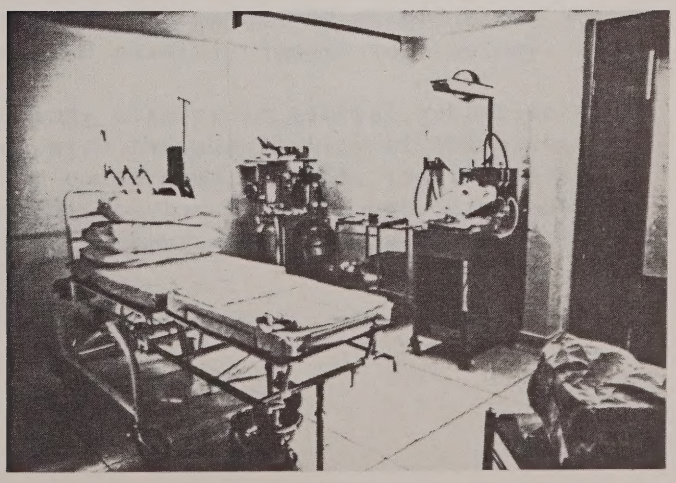
Obstetrics Dept.



BURY ST EDMUNDS



FRIMLEY



INPATIENTS, OBSTETRICS

This section covers the entire obstetrics department and includes:

Central Delivery Suite
Special Care Baby Unit
Ante-Natal and Post-Natal Beds
Isolation/Segregation Unit
Obstetric Outpatients

Where appropriate notes on obstetrics and gynaecology will also be contained in the section 'OUTPATIENTS AND DAY PATIENTS'.
Central Delivery Suite will also be mentioned as appropriate under 'TREATMENT AND DIAGNOSTIC SERVICES', and reference to the mother and child units in the Psychiatry department will be made under 'INPATIENTS - PSYCHIATRY'.

LOCATION AND DESCRIPTION

Obstetrics and Gynaecology Clinic:

This is situated on the ground floor between the far (inner) end of the Snack Bar concourse and the Dental OPD. There are 2 consulting rooms, 6 cubicles, and a waiting area.

Central Delivery Suite and Special Care Baby Unit:

These are located on the first floor in the central core facing the Maternity wards, with a link corridor connecting to the 'far' end of the Operating Theatre Suite.
Accommodation includes offices, admission area, dual purpose 1st stage/normal delivery rooms (8), multi-purpose room for 3 patients,
Abnormal delivery-rooms (3)
20 places for babies in the SCBU.

Maternity Beds;

The post-natal, ante-natal, and segregation wards are grouped around the Central Delivery Suite towards the rear of the hospital on the outer side of the street. They are interconnected by an internal 'corridor', and are accessible from the street by link corridors containing ancillary rooms.
A total of 85 beds were provided (8 for barrier/segregation nursing) and 4 nurseries which could double as single rooms were included.

PURPOSE, FUNCTION AND ADMINISTRATION

Obstetric and Gynaecology Clinic:

Starting appropriately with outpatients, the 'Best Buy' objective of making extensive and effective use of facilities determined that no duplication of these facilities should be necessary, and that the maternity clinic would also be shared by gynaecology, family planning and possibly female venereology.

The planning of the obstetric and gynaecology clinics in general outpatients was intended to work in a flexible manner with the possibility of GPs using such facilities, and the consultants being encouraged to go to local health centres and surgeries. 'Ultimate responsibility for patients attending hospital clinics will rest with the consultant obstetrician' and 'all patients

booked for hospital will attend once or twice to make sure that the patients records have been commenced, to be examined by a consultant obstetrician and to enable the patient to see the in-patient department'.

The clinic particularly was to provide a screening function for the estimated catchment area of 170,000 people, with differences being made up in Frimley by the Aldershot Military Hospital (which would be responsible for an additional 20,000 population). Treatments and investigations were to be limited to those possible in consulting/examination room the more complicated procedures being referred to the appropriate in-patient or day beds and to the Central Treatment Suite.

The following sessions/week were intended:

ante natal clinic sessions	4
post natal clinic sessions	1
combined ante-natal and medical	1
gynaecology	2 + 1 special investigation
family planning	2) 'some of these may be evening sessions'
venerology	1)

The midwife in charge of maternity clinics would have access to all records, and within the clinic area there would be an office for a medical social worker, domiciliary midwives and a health-visitor.

Obstetric Inpatients:

Generally the purpose of the obstetric department was to permit all patients who wish to be confined to hospital to be admitted; and to provide facilities for the safe confinement of mothers, ante and post natal care of mothers and babies, the special care of babies requiring continuous skilled observation, and the teaching of pupil midwives and student nurses having obstetric training.

Teaching accommodation would include:

1 classroom, 1 seminar room,
1 study/periodicals room,
plus the facilities generally available in the Education Centre.

The provisions of the Delivery Suite, SCBU and Maternity beds were planned on a basis of 0.5 beds/1000 population with an estimated 2890 births/year envisaged.
Approximately 23 ante-natal beds would be provided, the rest (post natal) being allocated:

25% for up to 10 days - medical reasons
25% for up to 10 days - social reasons
50% for 48 hours - normal hospital and local authority procedures
A 70% occupancy rate was expected.

Delivery room requirements were:

1 dual purpose delivery rooms available for 24 hour occupation including the use of 3 for abnormal deliveries.

A barrier nursing-room was to be used where necessary, otherwise all deliveries would take place in the Central Delivery Suite or in emergencies in the Operating Theatres - adjacent.

The Consultants in obstetrics, paediatrics and anaesthetics would have overall responsibility, and nursing control and administration would be separate from the general division under a head midwife (divisional) and a senior (midwife) nursing officer.

Four catagories of patient care were defined as ultra-high (Central Delivery Suite, and SCBU and barrier-nursing) high, medium and low.

Apart from the 8 beds in the Maternity Segregation - barrier nursing suite, and the 3 beds (high dependency) in the Central Delivery Suite, the policy for all maternity beds was to be 'progressive-patient-care' and no distinction of ante-natal beds areas was intended. The maternity wards are contiguous with the gynaecology and it was intended that 'flexibility in use of the rooms (bedbays)' would occur ... 'in this area depending on the day to day needs' of the two departments.

As far as possible babies would 'room in' with their mothers, and four nurseries on the inner side of the corridor opposite the bed-bays were provided for those babies 'requiring special observation or who at night disturb other mothers'.

The milk-storage/demonstration area is intended to be used for mothers and nurse training (as are the nurseries).

INPATIENTS, OBSTETRICS — BURY ST EDMUNDS

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD, AND STAFFING

'Generally speaking the unit is very good, the patients certainly like it and so do the staff - we have made a lot of changes in the use of various rooms, we have had to ... but overall we like it'.
In fact the unit serves the purpose for which it was designed. The original assessment of need has not been justified - bed occupancy is 30.8% not 70%. The UK birthrate is now 12.3/1000 not 17.0/1000 as calculated. The full 85 beds were never opened and 58 are currently in use.

The allocation stands at:

ante-natal	= 22
post-natal	= 36
special care cots	= 12

(20 provided but average current occupancy is 7%). There were 1200 deliveries in the year of opening, the number now stands at 1600/annum. The number of non-hospital births has changed from 132 in 1975, 72 in 1976 to 22 in 1977.

The original policy suggesting that 50% of the mothers would be discharged after 48 hours has been changed to retain mothers for 6 days until breast-feeding is properly established. No one stays in for less than 48 hours. Although they cannot come in for all their patients, district midwives and general practitioners made 120 deliveries in the last year.

Administration:

A senior nursing officer (midwifery and community - part - District) is responsible to the District Nursing Officer directly and is not in the general division. Staffing is organised on a District basis and includes some community services in Thetford and Ickworth.
Links with the community are excellent and this appears to be aided by the hospital/community function of the SNO's job.

Staffing:

There are 3 consultant obstetricians and 1 paediatrician. Nursing should be on a ratio of 1:1 for the whole department but is considerably less as money is not available, it is said, to staff the unit properly. Housekeeping staff are used, the housekeeper mainly being responsible for clerical work.

ACCOMMODATION, DEVELOPMENT AND CHANGE

The location and access of the whole department to the rest of the hospital (and particularly theatres) is thought to be excellent. The ante-natal clinic, whilst being essentially sited on the ground floor, is staffed by the obstetrics/midwifery division and might preferably have been adjacent to the main department.

Delivery Suite:

The policy of having dual-purpose rooms is well-liked, although the rooms are considered only just large enough for the increasing amount of equipment being used (e.g. monitoring and induction of labour equipment). There should have been a complete system of oxygen and suction for both mother and baby.
3 abnormal delivery rooms were provided and it is felt 2 would have been sufficient.
The high dependency 3 bed unit in Central Delivery is not used as it is felt that ill patients or those being monitored are better in single rooms. The room is in fact used as (much needed) storage space, and for paediatric consultations.
No changing facilities are required between the dual-purpose and abnormal delivery-room, and as an integral scrub-up area is preferred the separate scrub-up area is not required.

The beverage point was sited by the staff-base: this is unsatisfactory as blood, and urine specimens are kept in this area.
The paediatric resuscitation room has been converted to a staff 'resuscitation' room - where beverages for anyone can be made. It was felt essential that staff should have a room where they could recover and have a meal as it is often difficult to leave the department, particularly at night.

The 'on - call' rooms are required for medical staff and students: there are usually 2 students in the suite at any one time.
The room allocated for secretaries is far too small. 2 secretaries keep patient records in this room, and send them to the ante-natal ward when required, the records system is separate from central medical records. The 'Congenital Disabilities (Civil Liabilities) Act : 1976' now necessitates the keeping of records for a minimum of 21 years.

S.C.B.U:

There are 12 staffed cots here, but the occupancy level does not often reach this number. The unit is well liked and 'very happy'. Mothers do not generally stay in the unit (there is no 'hotel' - accommodation as mentioned in the policies) : they either stay in the post-natal ward or occasionally in the overnight rooms (D&E). On occasion, a bed has been put in one of the special care rooms so that mother and baby could be together.

The sisters/doctors room is shared but as it is open to a corridor from both sides it is difficult to hold confidential coversation. There is a need for mothers who come in for the day, to have a separate sitting area.

The milk demonstration room is used as a milk storage room - all items are disposable - and because of the trend to use expressed breast-milk, a deep-freeze has been added.

Ante-natal, and Post-natal Wards:

58 beds are in use, divided into 2 sections by fire-doors:
36 post-natal and 22 ante-natal.

The 2 staff bases were sited centrally and there is no clear division of the ward into 2 sections. The lack of management structure in the ward plan has resulted in difficulties for nursing management, and for flexibility of use.

The 36 bed section is felt to be far too large (20-30 would have been sufficient) and in general a contiguity of ward-sections like those for general acute in the rest of the hospital, would have been more satisfactory.

Some of the midwifery staff feel that ante-natal and post-natal beds should not be in the same ward. The ante-natal ward has no proper staff base and too few single rooms.

Day spaces:

These are inadequate. A 6-bed bay is now used as a day-room, and the original space is used for visitors. The milk-storage is not needed and is used as a district midwives office.

Single Rooms:

The 6 rooms provided are in constant use for ill patients, mothers who lose their babies, or for patients requiring segregation. The 3 nurseries are constantly used, in particular at night.

Offices:

Each housekeeper needs an office to do clerical work in. One uses the sisters office, and one office is taken over by a secretary.

Ante-natal Clinic:

The reception-area requires more privacy, the receptionist can never have a quiet talk with a patient.
Curtains are required in the cubicles as it is embarrassing for the patient to be undressing with the doctor waiting in the same cubicle.
The design of the unit in general is not liked because of the lack of privacy.

Teaching Accommodation:

24 students/year and 4 x 6 obstetric nurses/year are taken on. Although midwifery students were to use the Education Centre, this is not done as it is short of space and because it is felt that the school should be in the midwifery department: consequently there is not enough space for teaching purposes - the classroom and seminar/library are too small.

ENVIRONMENT, ENGINEERING

In the Central Delivery Suite the clerestory windows are troublesome, mainly in spring and autumn, and curtains have to be drawn all the time. Blinds are being installed in the dual-purpose rooms - but they are difficult to maintain.

The temperature of water in the bidets has proved difficult to control, the hand-sprays attached do not seem to have proved sensible as water gets all over the floor and inadequate wall splashbacks are provided. A central-nozzle spray would have been preferred.
Showers are used, but patients would have preferred baths.

Others

There is a trend to use greater amounts of mechanical/electrical equipment - particularly in the labour-rooms where resuscitators, over-head heaters, and heated mattresses for babies are used. Anaesthetic machines and infusion pumps are all taking up space.

INPATIENTS, OBSTETRICS FRIMLEY

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

This department is administered under the new 'Salmon' - 1974 - 'Maternity and Child Health Division'.

The Division consists of:

Central Delivery
Special Care Babies
Ante-natal Clinic
Segregation Unit (not in use)
F11a) Ante-natal and Post-natal Beds
F11b)

F 9) Gynaecology
F10)

F 1 Paediatrics
Community - nursing

The original basis of need has not been justified. Although the population has jumped from the expected 170,000 to 260,000 in 1977 there were 2100 births, representing a 99% hospital confinement.

Length of stay patterns stand at:

40% for 48 hours
40% for 4-5 days
20% for 8 days (all patients of one consultant).

A few patients delivered by the District Midwife go home after 6 hours.

The rate for Caesarian section is 8.1% - 69 elective
- 102 emergencies

There are 20 community midwives and liaison with the community is thought to be very good.
The policies, as written, have been faithfully followed but it has not proved easy to move on patients as fast as the senior nurse would like. There are some differences in the District between the delivery methods practised at nearby hospitals.

Administration:

The creation of the separate nursing division has created many problems for the hospital. It is the only division which has spare beds, and the hospital is very short of beds elsewhere. Because of the distinction between the divisions, these spare beds cannot be re-allocated.

Staffing:

A Divisional Nursing Officer is in charge of Maternity, Paediatrics, Gynaecology and Community liaison,

Senior Nursing Officers	= 2	: 1 for Service and Community 1 for Education
Nursing Officers	= 6	(until recently = 8)

A number of nursing officers in senior positions were drafted into the new hospital from smaller hospitals and this has left the department slightly 'top-heavy'. (Refer to the table on nursing establishment in 'ADMINISTRATION')

There are 3 consultants and 1 paediatrician.

Education:

28 students/year in 4 intakes are taken on. The original 6/intake (policies) was found to be too small, lacking in stimulus, and resulted in high wastage and a lot of sick leave.
8 obstetric nurses/intake are taken on - this will have to increase to meet EEC directives.

Housekeeping:

The housekeeping system is not considered satisfactory as it should be part of a multi - disciplinary team (this does not happen). There are certain 'industrial - relationship' problems.

Nursing auxiliaries have changed to become ward-clerks in the gynaecology and post-natal wards.
It is thought that new staff should be each given a copy of the operational policies.

ACCOMMODATION, DEVELOPMENT AND CHANGE

Delivery Suite:

There appear to be no problems here. It is well liked and although the dual-purpose rooms are small for the increasing amount of apparatus being used (25% - 50% patients are being induced), they function well.

The 3 bed high dependency room is not often used. The abnormal delivery rooms are used frequently for special cases and are particularly useful when the patient has to remain for any length of time.
Storage is generally inadequate.

Because staff in the Central Delivery Suite wear theatre-gowns, there appears to be no problem about taking patients to the Operating Theatres when necessary, but shoes are changed.

S.C.B.U

12 out of the 20 cots are staffed (funded), and this is felt to be sufficient as a change in policy requires that only sick babies are kept here. Those requiring phototherapy (eg for physiological hepatitis) now use apparatus placed in the post-natal ward. Similarly babies from caesarian or breech deliveries go to the ward so that they can be kept near to the mother.

There has been marked decrease in the number of cots required: often only 1 or 2 are in use.

Ante-natal and Post-natal Wards:

Ward management has not been easy as the ward-design does not allow flexibility - only one area has a nurses station. It is felt that the ante-natal wards should be entirely separate from post-natal.

54 post-natal and 25 ante-natal beds are provided, the post-natal beds are divided into 2 sections for management, but for all sections there appear to be insufficient single-rooms and ancillary spaces.

Day spaces:

Sited in the link corridor, the day room is not satisfactory: The day-room of the adjacent gynaecology ward spills into the ante-natal ward which is also considered undesirable by some staff.

Patient facilities:

Generally these are satisfactory. However the translucent glass in the showers does not provide adequate privacy and several patients have been visible and identifiable from other parts of the hospital. The one bathroom has had a couch put into it to enable treatments to be carried out.

Ultrasound:

This was not allowed for in the original policies, but has in fact been added to the X-ray department. It is used frequently. (refer to X-ray Department).

Ante-natal Clinic:

Particularly the lack of privacy resulting from the design was mentioned.

Teaching Accommodation:

Facilities in the department are inadequate. The seminar room in the gynaecology ward is now also used. There is no room available for midwifery students in the Education Centre.

ENVIRONMENT, ENGINEERING

The Central Delivery Suite particularly suffers from excessive heat-gain, and from the glare through the clerestorey windows.

OTHERS

The Maternity Division includes gynaecology beds, of which there are 57: at least 10 more beds are required, but mainly because of the large size of the section it has proved impossible to share with midwifery. 'Ante-natal patients and gynaecology patients should not be in the same ward'.

INPATIENTS, OBSTETRICS CONCLUSIONS

The obstetric needs of both Districts have been met in spite of the great differences in population between the two areas. In fact for both areas too many Maternity beds were provided. As a result of different trends in practice the Special Care Baby Units in both hospitals are also too large - a maximum of 10 (rather than 20) would have been sufficient.

Barrier nursing units are not required - a patient requiring isolation is sent to the isolation ward.

Community liaison is excellent, but it has been found that length-of-stay is increasing because it is considered better for the mother.

Peripheral banding of the Post-natal and Ante-natal beds in sections of 52 and 24 has not been satisfactory: the 52 bed section is too large, resulting in lack of ancillary rooms for the functions of the midwife, when the beds were divided into 2 sections. The sharing of ante-natal areas with post-natal or gynaecology is not considered satisfactory, or even desirable.

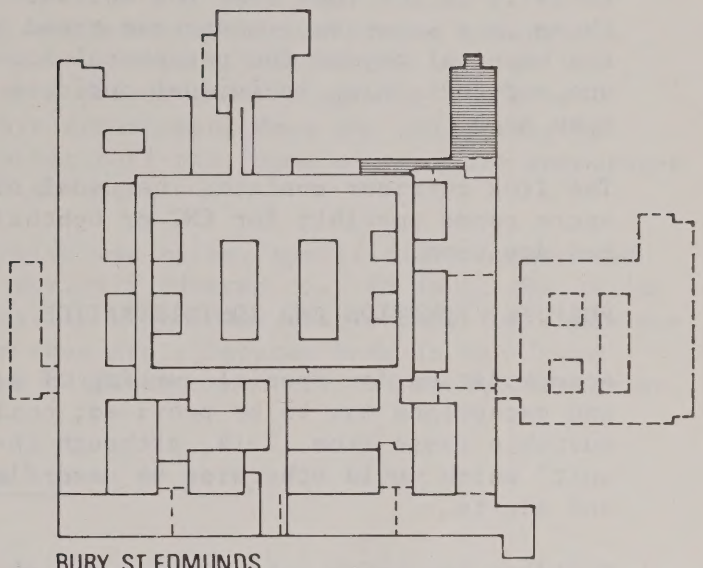
The administrative pattern at Frimley Park prevents use of empty beds for other specialties - this causes great difficulties owing to shortage of beds in the general division.

Full integration of the Maternity department is well-liked and in particular the pattern of care within the Delivery Suite with the link to the Operating Theatres and to SCBU is considered good.

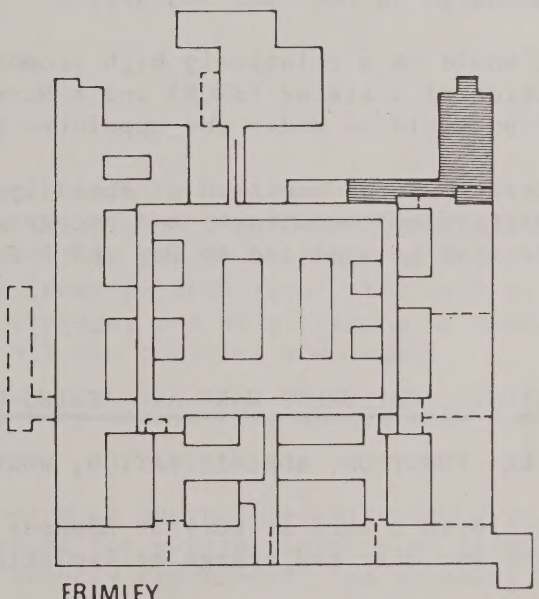
Economy in design is felt most in the lack of storage space, poor robustness of walls etc, lack of splash-backs in washing areas, and in the lack of privacy.

Change in room-function has been made, for example, in the use of offices, and fortunately because of the lack of need for some 6-bed bays, adequate day-rooms have now been created.

Children's Beds & swing-unit.



BURY ST EDMUNDS



FRIMLEY

IN PATIENTS, CHILDRENS WARD AND 'SWING-UNIT'

LOCATION AND DESCRIPTION

This 24-bed ward and the 4-bed 'Swing Unit' between it and the ENT/Opthalmic/ Dental Ward, at the head of the link corridor, are situated on the first floor near the rear of the hospital. A small semi-enclosed play area is sited externally on the roof over the entrance to the Isolation Ward and in addition there is a separate grassed and treed playground area opposite this end of the hospital beyond the peripheral access road. The ward is roughly halved; one end containing individual cubicles or rooms, the other being a 10-bed open area.

The link corridor contains the usual offices, also a minor treatment room, two extra rooms possibly for ENT or Ophthalmic investigations and a separate 4-bed day room.

PURPOSE, FUNCTION AND ADMINISTRATION

Accommodation for special nursing of all children with the following inclusions and exceptions was to be provided; children from 0-12 years, and also where suitable those from 12-14, although the latter may be placed in the 'swing unit' which would otherwise be used flexibly between ENT/Ophthalmic children and adults.

Children requiring special care and observation and infants would be allocated the cubicles or 2-bedded rooms at the far end of the ward; older children might also be allocated the 2-bedded rooms. All other children would be accommodated in the open bed area.

There would be a relatively high proportion of fully trained nurses under the direction of a sister (SRCN) and a Nursing Officer. The overall medical administration would be under the appointed paediatrician.

Children would be admitted as speedily as possible under the care of their own particular consultants and emergency admissions would come straight here rather than be admitted to Day and Emergency beds.

INPATIENTS, CHILDRENS WARD AND 'SWING-UNIT' BURY ST EDMUNDS

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

The children's ward at Bury St Edmunds is under the supervision of a Nursing Officer who also has charge of isolation, ENT and Ophthalmic wards.

Children are accepted between the ages of 0 and 13 years, and the occasional 14 year old might be admitted. Admissions are accepted straight into the ward - following the admissions policy.

Partly because of the geographical location of the hospital and partly due to administrative changes, a number of procedures differ from those originally laid out in the Planning Policies.

The 'swing unit' is never used by children, the main reason being the difficulties in observation (as the unit is sited outside the ward entrance). For similar reasons the Day Room at the hospital street end of the link corridor is not used as intended, indeed the children who might have used it are admitted to the 'open area' of the main ward. This is because of problems of fairly long travel distances after minor operations. In fact, the Day Room is used for play, an important consideration - and for some educational instruction.

ENT and Opthalmic child patients are not accommodated either in the children's ward or in the 'swing unit'; instead they have been allocated the nearest bay in the ENT ward where it is considered that proper trained nursing would be more immediately available. Although this arrangement does not suit everyone, it is not unwelcome to the majority of other patients, some of whom are encouraged by the childrens presence to go and read to them.

Finally, the 'pattern of patient care' which was rather specifically determined by the use of each room or space is not strictly adhered to. In fact, the children are classed either as high dependency, in which case they occupy the individudual cubicles, or as low dependency when they are allocated beds in the 'open area'. Only in special circumstances are children ever referred to the Isolation Ward.

The staffing structure at present stands at:

1 Sister SRN, RSCN
1 Staff nurse SRN, RSCN
1 Staff nurse SRN
1 SEN
9 students/pupils
2 nursery nurses
1 nursing auxillary

ACCOMMODATION AND ENVIRONMENT

In general the ward appears to be very successfully designed for flexible use, although some staff would prefer to have the higher dependency beds nearer the nursing-station, for ease of observation. This latter has been achieved at the far end of the unit, by knocking out (down to desk level) the wall of the room designated originally for disposal storage, and by placing a secondary nurses desk there, commanding a view of all the cubicles and rooms.

That end of the ward still appears to be very dark at nights and some low level lighting is required.

The bathroom arrangements are flexible and much appreciated although - as at Frimley - no space or equipment was provided for washing nappies or plastic nappy covers (they do not often survive laundry treatment). As a result ad hoc wash-ing and drying arrangements of a rather temporary nature have been made, which are not entirely satisfactory.

The storage of supplies adjacent to the nurses station appears to be satisfactory but it has been found inhibiting not to have interchangeable shelves in the cupboard unit. The storage generally on the ward was sufficient, but recent increase in the requirements for machinery and equipment to be stored at ward level has created a small amount of congestion.

The disposal room suffers from lack of sufficient storage and drying space for bedpans and potties, and the structure of the wall has failed to support the fixtures supplied to hold the disposal bags.

IN PATIENTS, CHILDRENS WARDS AND 'SWING-UNIT' FRIMLEY

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

At Frimley, the children's ward comes under the overall jurisdiction of the SNO for Maternity and Child Health, and in particular is run by the Nursing Officer for Paediatrics and SCBU and by the sister in charge.

The ward accepts the 0-14 years age range including those classified for ENT/Ophthalmic treatment, ENT children (up to 6 or 7 children) are often placed in the 'swing unit' so that ENT nursing procedures may be confined to one area. This has proved a useful practice as the ward itself has a very high occupancy (up to 30 beds) and rapid throughput.

Up to 3 nursing teams operate, effectively dividing the workload between the 17 consultants who visit the ward, and patients are allocated to teams; only one team does a round at any one time, but the ward still remains very busy.

Two exceptions to the Planning Policies have been made. Firstly very few children are sent to the Isolation Ward, and secondly the use of the Day Ward as described has been dropped. As at Bury St Edmunds the room is used for daytime play and education under the direction of a nursery nurse.

Because of the 'hectic' pace of this ward and the number of very ill patients staff work in shifts with at least 3 qualified staff on every shift. The staffing allocation includes 3 sisters plus 10 trained staff.

ACCOMMODATION AND ENVIRONMENT

No structural alteration has taken place here, but it is felt that the ward should have been planned to place the high dependency end adjacent to the nurses station.

The bathroom arrangements are satisfactory but as at Bury St Edmunds there was the problem of how to accommodate the washing and drying of nappy covers and far too few shelves and cupboards have been fixed in the bathroom. It was also felt that the high isolated baby-bath was rather dangerous to use without a changing area/worktop adjacent.

In general, all areas of the children's ward appear bright, pleasantly coloured and homely in choice of furniture. Day lighting is well dispersed at a very good working level.

Although numerous departures from the Planning Policies have been necessary at both hospitals, it is apparent that sufficient flexibility in design and procedure has been accommodated, that staff morale is high and that the Ward seems pleasing to patients, mothers and other visitors.

In both hospitals the Ward has accommodated more children than expected for different reasons.

In Frimley's case, the demand for high throughput of patients follows the general pattern in that area, in Bury's case the geographical spread of the catchment area has influenced the pattern of patient care and in-patient bed allocation.

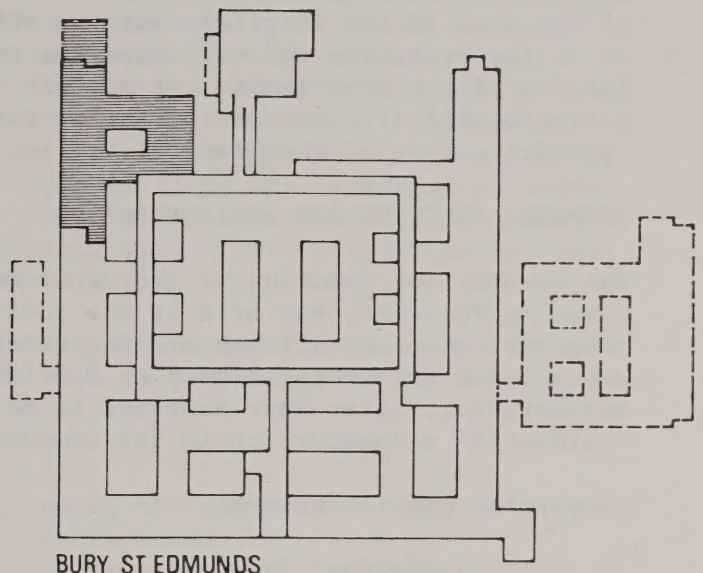
Neither hospital found the Day Room acceptable for observation or supervision of bed-bound patients and both have converted it for much needed recreational/ educational uses.

Particular attention should have been paid at detail planning stage to two areas:

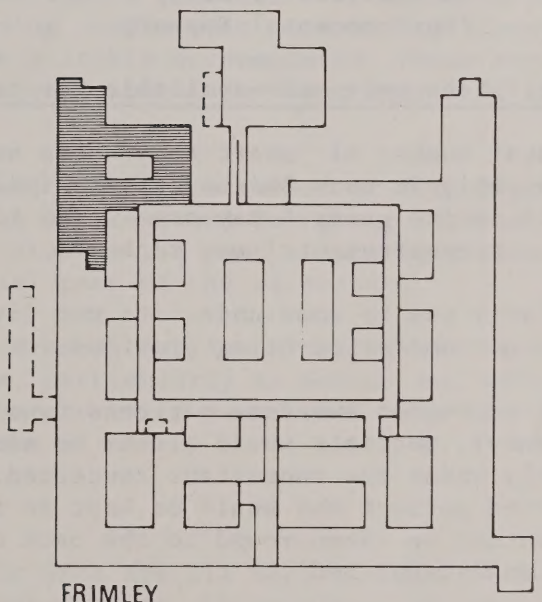
a. the bathroom and its requirements for fittings and changing-table/ shelf.

b. the observation (particularly at night) of the cubicles and surrounding rooms.

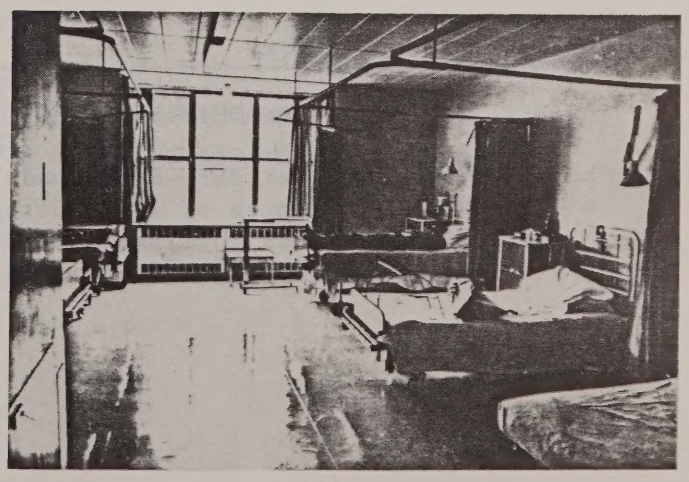
Psychiatry Dept.



BURY ST EDMUNDS



FRIMLEY



INPATIENTS : PSYCHIATRY

LOCATION AND DESCRIPTION

The Psychiatry department consists of 6-bed and 7-bed bays, 4 single rooms, 2 mother and baby rooms, treatment, day-centre activity and therapy spaces, ancillary rooms and consultants offices. These are 'grouped' on either side of a self-contained internal corridor, at ground floor level around a courtyard at the rear of the hospital, with an entrance from the 'street' opening directly on to the reception and waiting area, and a separate external entrance at the far end of the department. At certain times a small number of Psychiatry patients will also use one of the workshops in Occupational Therapy at the opposite corner of the hospital.

PURPOSE, FUNCTION AND ADMINISTRATION

The purpose and function of the department was not written up in detail in the Planning Policies, but briefly the idea was to provide a focus for total community treatment of acute illness or long standing disability. The number of beds was related to a total damand of 0.5/1000 population and the out-patient and day care facilities were supposed to be complemented by rehabilitation and residential accommodation in the community.

Treatment was to include:

Individual Psychotherapy
Group Psychotherapy
ECT
Occupational Therapy
'Environmental Support'

No facilities were made available for psychology.

The total number of 'short stay' beds was to be 53 and day-space was to be used infrequently in each bed bay if the individual wasn't able or ready to sustain himself in the general day area. The total number of day places (including inpatient requirements) was to be 70.

Psychiatry was to come under its own divisional nursing administration with office accommodation being provided for 2 sisters.

Excepting repeat overdose patients (who would be admitted via Accident and Emergency), patients would either be admitted via outpatient referral, or directly under the consultant concerned. There was also the occasional 'highly disturbed patient who would be kept in the ambulance and after initial medical examination be taken round to the back of the hospital for direct admission to an assessment bed'.

INPATIENTS: PSYCHIATRY — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The Psychiatry unit at Bury St Edmunds follows the functions described in the policies, but the length of stay averaging between 3 and 6 months (not described in the policies) means that acute treatment is variable and of a different nature to the pattern of the rest of the hospital.

Because of this and because the facilities for rehabilitation to the community are poor or far away (St Audreys Hospital - euphemistically a long-term rehabilitation unit - is over 40 miles away), there is a high occupancy level and it is often difficult to admit patients until they have reached a crisis level and need sectioning under the 1959 Mental Health Act.

The provision for facilities given in the policies did not allow for the additional problems of the resettled and retirement population being encouraged to come to the area from London and other conurbations. Partly as a result of this movement, there is now an increasing psycho-geriatric problem which may ultimately necessitate the building of a 200-bed unit - a possibility being considered at the moment - on site at the rear of the hospital. Some people feel that the 200-bed unit is a pipe dream, but it is acknowledged that morale of the staff in the department might be improved if by the provision of these extra facilities the department could be seen to be 'consuming its own smoke' by achieving a higher or more effective throughput. Particularly the new unit would be required to provide for medium-stay patients and for senile dementias.

More space would be required for exercise and dining facilities, and a separate set of OPD screening facilities available also to psychologists would be welcome.

Admissions:

Despite the problems of level of acute illness, the department takes all likely admissions for assessment apart from senile dementias.

Schizophrenics are usually rehabilitated and become occasional day-patients. A minority cannot be easily discharged and as well as causing a burden for their families, they can cause 'disproportionate problems within the hospital'. There are also difficulties with containing people with personality disorders; those with criminal tendencies cannot be suitably accommodated; those requiring close nursing care are placed under constant supervision from 2 or 3 of the departments nurses.

Drug addiction is not common in this area, although a number of drug overdose cases are accepted after treatment in the Accident and Emergency department. This situation was not originally apreciated by the rest of the hospital, but the consultants feel it to be an essential part of the after-care.

The mother-and -baby-units are considered excellent for treating the 'nasty and vicious' post-natal mental illnesses, particularly as mother and baby can be watched, and kept close together. The maternity department only deal with very temporary or mildly affected patients.

Outpatients and Referral Patterns:

Most referrals come from GPs, who in this area are all very closely in touch with the hospital. Many of them work part-time in the hospital, and the allocation of OPD facilities is oversubscribed. The 2 consultants and the 1 hospital GP practitioner hold 5 sessions/week in OPD.

All admission cases thought likely to recover within 6 months-1 year are not transferred from the DGH. The major problem the consultants have is trying to find sufficient hostel accommodation for other cases and for half-way rehabilitation.

Psychologist:

A psychologist with district responsibility is now additionally accommodated in the department: This was not anticipated in the policies.

Many staff are not aware of the usefulness of a psychologist, but working in conjunction with the psychiatrists, he is now setting up a service to aid the paediatricians, and to assess and treat people for phobias.

A large percentage (approx 75%) of patients are seen as out-patients, and a close liaison is maintained between the department, GPs, and occupational therapists - work capability assessments being a typical joint concern. Referral is made through the consultants and through other medical staff.

Although some group-therapy is practised, a large proportion of the psychologist's time is spent in 1 : 1 contact with a patient, particularly doing relaxation or test therapy where very quiet surroundings are necessary. The unit doesn't meet this need very well, especially as the level of noise - and confidentiality - is hard to confine.

The psychologist is also initiating educational sessions both for staff and patients; this work is carried out in conjunction with the nurse-training staff and with other specialists such as the dietician and the paediatrician. Generally, the department only partially enables this wide range of activities to take place. The design of the unit is somewhat inflexible and there is a great need for better planned day space, and for separate (non stigmatised) out-patients rooms.

WORKLOAD AND STAFFING

There are 2 consultants, 1 hospital/GP practitioner, 2.5 psychologists and a full complement of nursing staff under a separate divisional nursing officer. The workload is really affected by the length of stay of patients which is much longer than might have been expected from the policies. Only about 10% admissions to in-patient beds/year are likely to be rehabilitated fully within 3-6 months.

Attempts are being made to open a day centre in the town, and it is hoped that this will help the unit to increase its rehabilitation targets.

ACCOMMODATION

In general the provisions of the department were liked, although far too little day space had been provided. Detailed comments concerned the following:

1 There was little or no space for the psychologists.

2 The staff meeting rooms were inadequate and are now used for patients to see visitors.

3 It is difficult for a patient to retreat and gain privacy if he needs to, although conversely the unit is very easy to get out of.

4 No room is readily available for relaxation therapy; the treatment recovery room is used occasionally but is not ideal.

5 Not all patients (day/out patients) like to come to the department as it still retains a stigma. More small consulting rooms should be available in other parts of the hospital near the front.

6 Security of delicate or expensive equipment is a problem and the psychologist needs a test library adjacent to his relaxation room.

7 The treatment room is not adequate for anything other than acute treatment and anaesthetic facilities are poor.

8 The dining facilities are proving inadequate and cramped for the increased number of patients now being taken. One of the rooms originally intended for group therapy has now been commandeered to ease this problem.

9 The bed-bays are reasonable, although the innermost cubicles are claustrophobic and a number of 4-bed bays would have been preferred.

10 One or two 'discreet' secure rooms are felt to be required.

11 The nurses station and sisters office are not used as intended having had to be altered to function satisfactorily.

12 Storage facilities for patients clothes and property are insufficient (due to length of stay).

13 There is a general lack of suitable recreation space.

14 The small rooms for consultants/interviews are thought to be a reasonable size. Environmentally, however, they function very poorly, particularly in respect of sound and confidentiality. When patients are asked if they are confused and can hear voices, very often they can hear the same question being asked in the next room. None of the staff are satisfied with the performance of the structure and this lack of privacy.

15 The dormitories, whilst adequate, are not supposed to be used very much during the day (policies) and thus have a low rate of usage. A small number of intermediate bed-sitter areas would be appreciated - particularly for helping those patients who find it upsetting to constantly mix with others in the day areas. However, the mass provision of single bedrooms would probably lead to regression and a lack of pressure on patients to make use of their environment.

16 Courtyards are much appreciated, as they 'take away from the hospital atmosphere'. However, the patients don't use them, being encouraged instead to sit beyond the wards outside the hospital when the weather is fine.

ENVIRONMENT AND ENGINEERING

The most common problem in the unit is that of privacy in resting or in conversation. The structure seems to transmit sound and the gaps at the bottom of doors, and the lack of soft furnishings reduce sound attentuation. Patients become immediately aware of this when entering the department.

Security remains a problem, and a number of patients could more easily have been kept in a proper secure unit away from the hospital. Some patients clothes have had to be confiscated to persuade them not wander about the whole hospital. This is not 100% successful.

The working conditions in the reception area are poor; there is no natural lighting or cross ventilation. Also confidentiality for telephone conversation and admission - registration is impossible because the reception desk is open on two sides.

The psychologist not only requires silence to help assess and relax patients, but he needs a sound-proofed room where noise and sounds can be generated to acclimatise people to the causes of phobias. Neighbouring consultants have been surprised and distracted by sounds of people being ill and by 'thunderstorms' etc.

The psychologist would like a suite of two sound-proofed rooms where a 2-way intercom could be used so that a patient could be left alone and still be in contact with the psychologist in the next room.

OTHERS

The psychological aspects of this department have been included in detail because little information was provided in the policies. Two reports on the implementation of psychological services within the department have been written by the psychologis In addition, further reference should be made to the 'Trethowan Report - The Role of Clinical Psychologists in the Health Service'.

INPATIENTS : PSYCHIATRY FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

Because Frimley Park has the facilities of Brookwood Hospital in the locality, to which longer stay and psycho-geriatric patients may be referred, the department in the DGH is able to function very much as planned in the policies. Although there is still a need for long stay psycho-geriatric patients in this area of Surrey, there are fewer problems of disorientation amongst the increasing population. Rather more, the demands upon the hospital are for acute treatment for neuroses and for drug-overdose cases. (The incidence of mental illness and other problems is not necessarily wildly different from that in other parts of the country).

Admission:

As stated in the policies 53 beds and 70 (total) day patient places are available and most categories of mental illness are assessed and treated. Old people with 'affective disorders' (depressions) are accepted, but the department does not take usually people who suffer from 'organic deficit' (dementia or arteriosclerosis of the brain).

Overdose cases are seen in Accident and Emergency, Day and Emergency, and in the Medical Wards, they are admitted to the department only if necessary. This has caused major problems in the past, but the department now has a good relationship with the rest of the hospital and few people are apprehensive about the inclusion of the department and the acceptance of patients. A large number of overdose patients are referred to out-patients rather than being admitted.

Patients admitted, present a wide cross-section of mental problems but it is felt quite strongly that the unit is not designed or staffed adequately to cope with psychopaths.

Occupational/Day-Centre - Therapy:

A majority of the patients do some form of occupational therapy, but it is not felt to be satisfactory to continually mix inpatients and outpatients and the day space should have been split and more particular activity spaces provided. Additionally a small industrial therapy unit in the hospital grounds is required.

Day patients are treated by the psychiatrists and by occupational therapists who work closely together. Activities include ordinary occupational therapy and craft-work, relaxation and group therapy, drama therapy, cooking instruction and expeditions for agoraphobics.
Few patients come everyday as the programmes are tailored to a timetable. With more facilities the psychiatrist feels that the department could expand aspects of day treatment particularly with a view to increasing the throughput of the inpatients - encouraging them to become day patients and then outpatients.

Rehabilitation:

The facilities available in the Surrey area are extensive (see catchment area profile) and Brookwood Hospital - planned on a villa principle - is felt to be ideal for rehabilitation.

Housekeeping:

The department felt that the service is only partially effective, and it is possible that because of the nature of activities in the centre, a detailed analysis of such work should be carried out.

WORKLOAD AND STAFFING

No details were available on nursing staff numbers, although they were felt to be adequate and they provided satisfactory 'cover'. There is only 1 psychologist, who is helped by 2 part-time staff.
There are 3 full-time adult psychiatrists, 1 psychogeriatrician (6 beds) and 1 child psychiatrist (2 beds).

The increase in catchment area population has probably affected the department beneficially in that policies have been geared to achieving a fast turnover of patients. The major impediment to this policy has been the dire shortage of day patient space.
Details of patient numbers and movements are included:

1 February 1977 to 31 January 1978

Inpatients	Admissions	- Male	=	150
		Female	=	344
Total inclusive of patients being treated at present			=	494
	Discharges	- Male	=	148
		Female	=	334
		Total	=	482
	Readmissions	- Male	=	29
		Female	=	95
		Total	=	124

Day patients (From 1 March 1977 to 31 January 1978)

Admissions	-	Male	=	34
		Female	=	82
		Total	=	116
Discharges	-	Male	=	15
		Female	=	58
		Total	=	73
Readmissions	-	Total	=	14
Total number of daily attendances			=	3062

Patients admitted under the 1959 Mental Health Act:

"	"	" Section 25	= 21
"	"	" Section 26	= 14
"	"	" Section 29	= 37
"	"	" Section 30	= 21

ACCOMMODATION

The major criticism of the department is that there are not sufficient day places for the in patients and that 70 day places do not really exist. The day area is felt to be like a 'corral' designed with general medicine in mind, rather than for the special needs of psychiatric care. This is echoed by the occupational therapists who feel the unit is 'too open plan'. Other comments in detail include:

1 Lack of appropriate waiting areas for people coming to see a consultant.

2 The bed-bays are reasonably supervised from the nurses station. Most people pass the nurses station when moving around the unit, this aids observation and 'control'.

3 The nursing officers room has been converted into a single bedroom and a room behind the nurses station has been made into an office.

4 There is no special space or room where relatives can meet patients in private. 'They go for walks round the corridors'.

5 The bed-bays themselves are 'on the small side' ... 'if you haven't got claustrophobia when you come, you'll certainly have it when you are here'.

6 The ECT room is small, cramped and lacking in proper back up facilities, and the circulation in the adjacent recovery room is seriously impeded by the central placing of the column, between the beds and the doorway.

7 A secure room with a one-way mirror and soft fittings is needed.

8 Sound proofing is needed generally, although the problem is not as great as at Bury St Edmunds.

9 Special facilities are required for the community nurse.

10 The allocation of offices to part-time consultants needs to be rationalised.

The nursing staff generally thought the accommodation to be good. 'At least they departed from the old workhouse style of institution'.

OTHER

Security and the location of the department have caused a certain amount of concern. It is easy for patients to wander - one went into the Operating Theatres ...' the surgeon was very angry', two patients disappeared and were eventually found attending lectures and lunchtime presentations in the Education Centre, and several patients have gone onto the wards to help putting other patients to bed. The nursing staff feel that an 'experimental' security officer might help.

As at Bury St Edmunds, storage has been a particular problem. Patients need more storage space than the average in-patient because of longer lengths of stay and because of the policy of patients wearing their own clothes.

IN PATIENTS : PSYCHIATRY CONCLUSIONS

Whilst the Psychiatry departments at both Bury St Edmunds and Frimley follow the scope of assessment and treatment laid out in the policies, neither hospital is satisfied with the space given to the department for different reasons.

In Bury's case the length of stay of patients is much longer than expected - facilities for 'throughput' and rehabilitation are poor in the community - and a wider variety of day areas is required. Additionally there are too few rooms for individual consultants, psycho-therapy or relaxation, and what rooms are provided have poor acoustic properties which aids neither confidence nor privacy.

In Frimley's case the throughput of patients is probably faster than expected but the day areas are felt to be unsuitable for mixing different categories of mental illness, or for mixing day and in-patients.

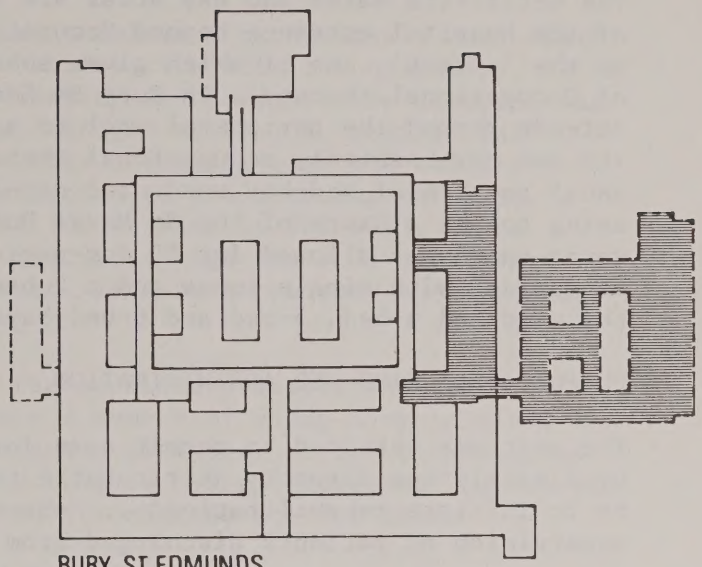
Generally the environmental problems of noise and light have not been satisfactorily sorted out. In particular sound from adjacent rooms or from the department above (Maternity) have proved distracting and confidential conversations are nearly impossible. The light in the bed-bays is not good for the innermost cubicles and contributes to the claustrophobic atmosphere of the wards.

As units designed for acute short stay assessment and treatment, the psychiatry departments at both hospitals would work well, and are, as such, appreciated. However, back up facilities at Bury and ease of access at Frimley (into the community) have not been logistically successful. Another problem at Bury has been the impact of a changing catchment area population, with growing numbers of elderly people and an increasing potential for psycho-geriatric problems.

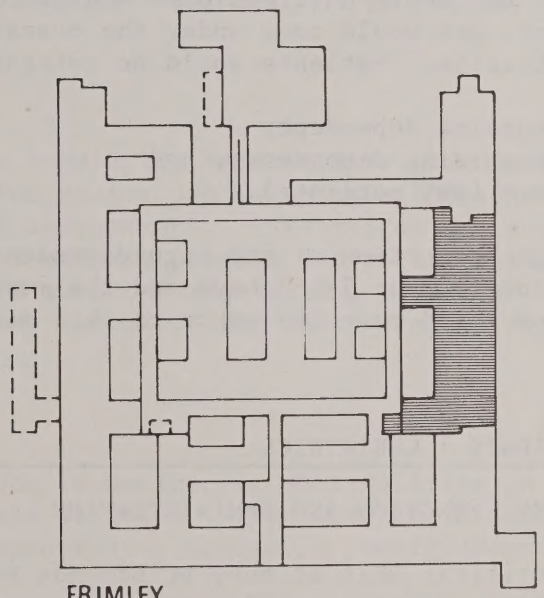
At Frimley the catchment area population has increased and put a general strain on the medical/hospital services.

The result of implementing the psychiatry department is that at Bury a new unit on site will be required (up to 200 beds) and a specialist psycho-geriatrician will be needed. At Frimley there is lack of appropriate day patient facilities.

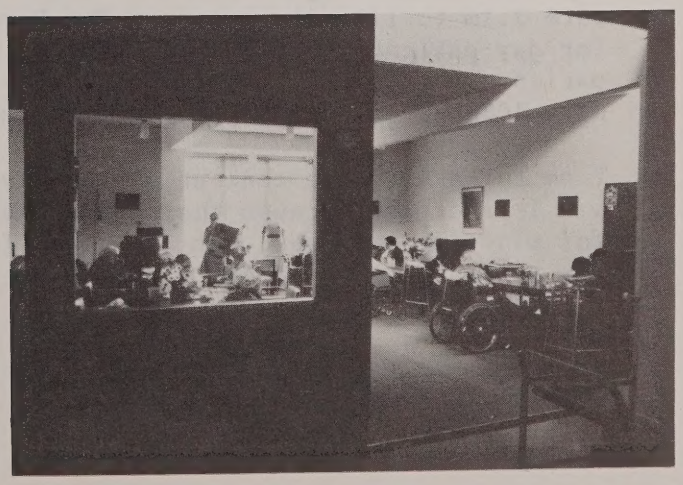
Geriatrics.



BURY ST EDMUNDS



FRIMLEY



IN PATIENTS : GERIATRICS

This section includes all in-patient geriatrics, and in addition all information on the functions of the Geriatric department as a day centre.

LOCATION AND DESCRIPTION

The Geriatrics wards and day areas are sited on the ground floor to the right of the hospital entrance beyond Occupational Therapy. There are 2 link corridors to the 'street', one of which gives shared access to the workshops and offices of Occupational therapy. In Bury St Edmunds case, this latter link corridor extends beyond the peripheral wall to a new 2 storey Geriatric block containing its own day hospital, occupational therapy rooms, and kitchens, as well as the usual pattern of bed-bay wards and day-spaces. (This extension was necessitated owing to the closure of the St Marys Hospital to in-patients). In the 2 original wards space was allowed for 30 day-patients, and for 50 'acute geriatric assessment beds' with single rooms and a 2 bed unit sited on the 'inside' half of the ward and 4-bed, 5-bed and 6-bed-bays sited opposite on the periphery.

PURPOSE, FUNCTION AND ADMINISTRATION

The unit was intended to permit care for in-patients 'suffering from illnesses or disabilities directly attributable to advancing age', and 'its aim would be to initiate rehabilitation' ... where possible ...' and to continue the supervision of patients discharged from hospital'.

It is assumed that progressive-patient-care would be practised and that whilst 'sections may be staffed by a fairly high proportion of part-time and non-nursing staff' the whole unit would be managed under an SNO or Divisional Nursing Officer, and would come under the overall responsibility of a Consultant geriatrician. Patients would be categorised in three groups:

High nursing dependency
Medium nursing dependency, and
Day care (day patients).

A large proportion of the high-dependency patients would be bedfast, and would be allocated the 5-bed-bays and the majority of the single rooms, with a nursing-station sited near the entry to this section.

INPATIENTS : GERIATRICS — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The geriatric unit at Bury St Edmunds has developed in 2 phases. The first, at commissioning, in 1974, was to provide assessment beds only. Rehabilitative and continuing-care patients were to be accommodated at the St Mary's site 2.1m (1 1/2 miles) away. The Department acknowledged that space allowed for day-patients was limited; but in any case District wished to move St Mary's patients to the DGH. The second phase, completed in 1976, was the provision of a 108-bed extension incorporating a day hospital.

From the start, the concept of the day hospital within the initial ward areas was impractical because there was insufficient room (no 'rooms' were available for planning purposes, but 30 square feet - 3 sq m per person was required for day places).

The catchment area demands on the unit have been changing, and the influx of young families with elderly relatives and a substantial 'retirement population' from the GLC area into Essex and Suffolk has also put a heavy weighting on the departments services. Newmarket was supposed to relieve this load, but it takes mainly patients from the Cambridge area. Ipswich and the nearby Norfolk facilities are also somewhat oversubscribed, so the catchment population dependent upon the new DGH has substantially increased.

Distances to the new unit have also caused problems - particularly over visiting and the psychological contact and rehabilitation with the community. This and the fact that there are too few day centres and homes in the district has altered the policy of the unit which now contains up to 10% 'residential' patients who could be in the community - this coincides with the national figure. Conversely and rather in contradiction to the planning policies, a large number of the patients are very ill (death rate is 30%-40%). As a result the demands on the nursing staff require a high level of experience and skill at monitoring and caring and there is thus a tendency to move away from progressive patient care policies.

Two other types of patient also require the specialist skills and can only be partially catered for. Firstly, there are a number of young chronic sick; tetraplegics, Huntingdons chorea multi-neurone diseases, stroke illness, but mainly disseminated sclerosis. A new day area is being 'tacked on' to the end of the day hospital to provide some degree of independence for them.

Secondly, there is a considerable demand for psychogeriatric services and it is felt that the unit is not well equipped to provide for such patients. The psychiatry department 'will not touch' geriatrics and consequently GP's refer patients to the geriatric department where they 'feel like a fish out of water' and become 'difficult to deal with'.

Day Hospital:

The day hospital service in the area has been split between Bury, Thetford and Sudbury. At Bury, the unit is staffed by its own Occupational Therapists (who work independently from the main OT department). This system was a natural follow-on from the old hospital and has been kept because the geriatrician feels that the patients require short bursts of activity over a long period of time rather than the 'heavy-workshop' treatment for which the main hospital department was designed.

Resuscitation:

The skills of the nurses are employed more in monitoring abnormalities in heart rhythm and in caring for hypothermic patients rather than in intensive resuscitation. For the latter, where appropriate, access is freely maintained to the ITU.

Housekeeping:

This has been readily accepted by the unit; the nurses jobs are greatly facilitated and the system is welcomed by the sisters. In addition, the unit is pleasant to work in and like the rest of the hospital it lacks the traditional hospital smell.

WORKLOAD AND STAFFING

With the addition of the 108 in new unit, the total number of beds open is now 158.

50 are allocated to assessment
49 - " " - rehabilitation
54 - " " - continuing-care/slow stream rehabilitation
5 - " " - young chronic sick (in rehab ward)

The 5 young chronic sick beds and 10 others are allocated as non-geriatric cases including orthopaedic rehabilitation.
A large percentage of the beds are occupied by women and the men are contained on one ward.

Every ward has 2 ward rounds/week and case conferences are held with occupational therapists, physiotherapists, speech therapists, liaison health visitors, staff nurses and hospital social workers.
This group maintains a close contact with the Local Authority services.

The throughput of patients is about 784 (1977) with a 5-6 persons/bed/year rate of usage. Average length of stay is meaningless as the conditions of the patients vary too much.

As has been stated already there are not many low dependency patients and in many areas the patient/nurse ratio needs to be 1:1. This target is not achieved, although the nursing establishment is complete, and there are no recruiting problems.

The geriatrician works with a senior registrar and a registrar and attends at least 1 OPD session/week in the department.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

The provision of the new unit has been very much appreciated as it brings the day hospital and the rehabilitation facilities close to the hospital (previous accommodation was becoming highly unsatisfactory).

Generally, the position relative to other departments in the hospital - such as Pathology - is considered good, although separate facilities for the young chronic sick would have been preferable.

In detail, several comments were made:

1 The small treatment room within the geriatric department is appreciated because it avoids having to 'cart elderly people around'.

2 The nursing units are slightly too large and provide too few facilities for relatives/visitors and they are lacking in privacy.

3 The WC's are poor for elderly or handicapped people. The doors are awkward to operate (as is the light) when a walking-frame is being used. There is a lot of difficulty in accommodating wheel-chairs as the wash basins get in the way and the grab-rails cannot easily be used.

4 The zoning of facilities generally is good, but storage is poor, particularly for patients clothes.

5 There is not enough day space and insufficient space is available for therapy.

6 Linen supply and exchange is not working well.

7 The bed-pan disposal units are not reliable.

8 The nurses stations are considered well sited.

INPATIENTS : GERIATRICS FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

Because of the availability of beds at Farnham and because there is no considerable change in the services expected from the catchment area, the unit at Frimley functions very much as planned in the policies.

50 beds is considered too large a unit and it is felt that the amount of day space allocated is too small.

The longer stay patients are generally referred to Farnham or to the extensive number of day places and hostel places in the community. As a result, the facilities in the DGH tend to be used for fairly ill patients and the geriatric wards are run on the lines of the medical wards.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

A number of useful comments included:

1 The bed-bay divisions were considered too small for geriatric chairs and lockers - this resulted in damage to furniture.

2 One of the nursing stations was wrongly sited.

3 The day room at one end was considered wrongly placed.

4 The level of the site alongside the wards was too high and produced a submerged depressing feeling with poor prospect.

5 Colours and decoration were considered depressing.

6 There was no separate space in which the physiotherapist could work.

7 The number of lavatories was insufficient and they were considered poorly spaced.

8 The corridors were considered too narrow, and there was a need for wall-bars to help patients manoeuvrability.

9 Doors to the single and twin bedrooms were considered too narrow and caused difficulties to non-ambulant patients.

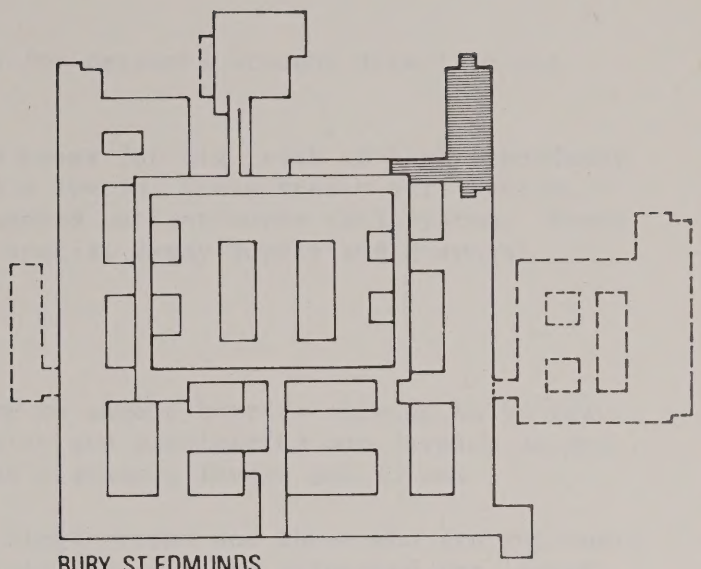
Perhaps more than any department but the psychiatry department, the geriatric departments at both hospitals have reflected in their functional policy, development and change, the impact of the hospitals' new position in their changing catchment areas.

Frimley has seen an increase in its young commuter/armed forces population. The families are mobile, housing is of good quality, services and facilities in the community are numerous, psychiatric and geriatric services are well provided in other hospitals and the Geriatric department has been able to follow the policies (and indeed the principles of Best Buy planning) fairly closely. The 'major' problems seem to concern detailed points of design. The problems faced by disabled patients are typical throughout the hospital and close attention should now be paid to ameliorating the conditions by more considerate detailed design.

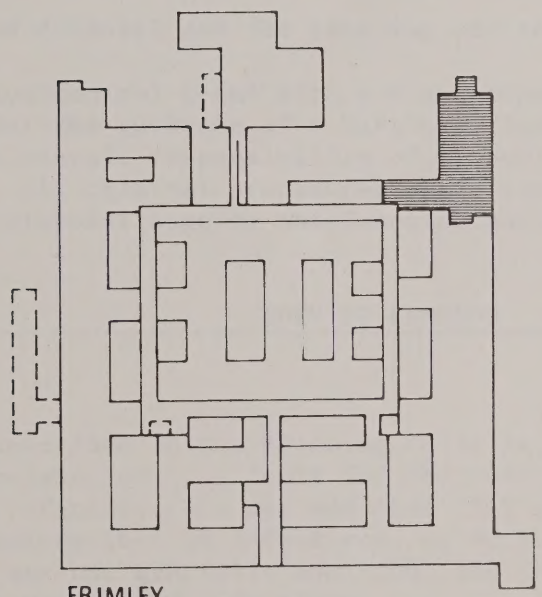
At Bury St Edmunds, the policies have not accurately reflected the way that the department has had to unify all the aspects of geriatric care, or the way in which it has become more of an isolated entity, taking on part of the workload of other Area authorities, and even providing for the complex needs of psycho-geriatric patients. The region around Bury St Edmunds has numerous problems of communication and transport. It is geographically a much bigger catchment area than that at Frimley, and the housing conditions and way of life are perhaps more varied. Both Suffolk and Essex have seen the influx of overspill populations from the large towns and the settlement of a new retirement generation. These two factors have resulted in unexpected demands being made upon the hospital services, and in a number of people being confused with or disorientated by the characteristics of a country way of life.

With its new block of 108 beds and day hospital space providing rehabilitation and chronic sickness facilities in addition to the assessment beds of the original hospital plan, Bury St Edmunds now provides what is felt to be a more integrated service. There are substantially more high dependency and ill patients using the facilities than was expected, but the pattern of care has been adapted to provide for them and the design and extension of the department has now accommodated this change in policy.

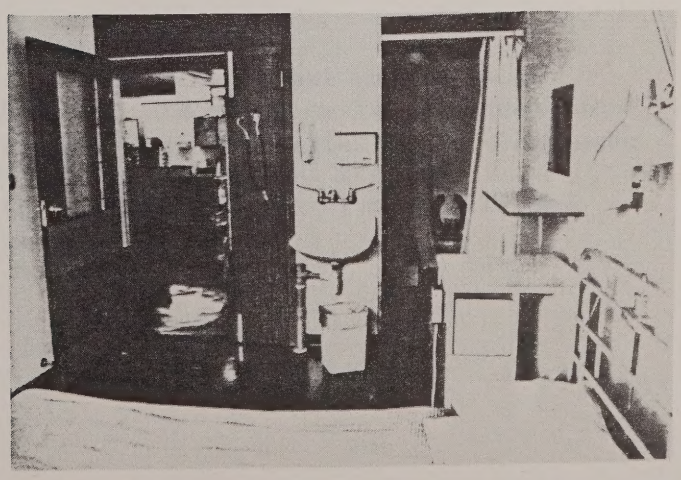
Isolation Unit.



BURY ST EDMUNDS



FRIMLEY



INPATIENTS: ISOLATION UNIT

LOCATION AND DESCRIPTION

This unit, located on the ground floor at the rear of the hospital does not interconnect with the adjacent geriatric wards, having its own 'link' corridor to the hospital street.

A separate external entrance is provided for patients brought direct to the unit by ambulance or other transport.

The unit contains 20 single-bed rooms; 6 rooms for high risk or high dependency patients have mechanical ventilation and a special 2-way speech call system, the remaining 14 rooms will have the standard patient/nurse call system. Every room has a shower and WC en-suite, with special 2-way supply and disposal hatches adjacent.

PURPOSE, FUNCTION AND ADMINISTRATION

The purpose and function of this unit are to enable barrier nursing to be practised for all patients (including maternity and paediatric) who develop or are suspected of developing highly infectious diseases, fevers and so on.

All patients are to be contained in the single-rooms and those who are seriously ill or who need skilled nursing and medical care will be allocated the 'internal' side rooms (which are slightly larger) all of which have oxygen and suction outlets.

Special arrangements for linen supply and disposal and for catering are required.

The ward sister (a member of the infection control team) with a high proportion of trained nurses, will run the unit under the guidance of a Nursing Officer (Grade 7) and the unit will be under the overall responsibility of a specially trained consultant. As far as possible, all clinical procedures would take place in the patients rooms and special disposal bagging and decontamination procedures are followed.

INPATIENTS : ISOLATION UNIT — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The unit fulfils most of the functions described in the Planning Policies, although it was felt that it should be relabelled; ... 'unit for the controlling or containing of infectious diseases' ... Patients are not admitted 'for social reasons' but an extra category - those susceptible to infections, eg burns patients - would be accepted. Children are not generally admitted, and the unit is used primarily for patients with ward-wound infections.

WORKLOAD AND STAFFING

Although only 10 beds are funded for use, sometimes the actual number is 13 or 14. Although the policies indicated that patients might be fairly independent, the actual majority are highly dependent and they are classified by the 'Aberdeen Formula' which also records numbers of patients and length of stay.
A bacteriologist acts as overall adviser to the organisation of the unit, and patients are admitted under their own clinician.

The nursing establishment includes:

1 sister
1 staff nurse
2 staff nurses (part-time)
3 student/pupils
1 nursing auxiliary

On night duty 1 SRN and 1 Auxiliary are usually present.

ACCOMMODATION

The provision of single rooms throughout is much appreciated, although observation is difficult. The pass-through cupboards are used for clean items only. Only 2 rooms large enough to take beds with traction has proved somewhat inconvenient, and the unit appears to be short of a second bathroom and a relatives overnight room. The doctors room has been found unnecessary but the provision of a gowning room would have been very useful.

Following the general pattern of hospital practice, more equipment is being used than was allowed for in the Planning Policies - vast storage areas are still required.

The separate entrance is much appreciated, providing direct access for patients coming from home and allowing patients to move out into the gardens from their beds (weather permitting).

Two other comments concerned the en-suite shower areas, and the wash hand basins. The former are considered 'tight' spaces particularly for those with transport aids, wash hand basins in the rooms are too open to offer any privacy (from visitors etc) and for good infection control reasons, a wash hand basin should have been located outside each room.

ENVIRONMENT AND ENGINEERING

Sound insulation has caused certain problems for confidential conversations. Ventilation is poor in all areas and the mechanically ventilated rooms have not yet been used as such. Oxygen and suction were only provided in 6 rooms. This is considered insufficient.

OTHER

The policy stated that a special bulk food supply catering policy would occur in this ward. This has not been successful. In fact, a plated-service is being proposed, and the meals are served on 'disposable china'. The kitchen wash-up area is not used.

PURPOSE, FUNCTION AND ADMINISTRATION

In general, length of stay is greater in comparison with other wards.

Admissions include:

1 Patients receiving protective isolation
2 Dermatology patients (7 beds)
3 'Metabolic' patients (1 bed)

Children are not generally accepted to the unit.

WORKLOAD AND STAFFING

In all, 19 beds are available; the occupancy usually reaches 11, but it has been as high as 17.
Patients from St Peter's Hospital, Chertsey, and from the army also use these facilities.

The nursing establishment stands at:

2 sisters (1 part-time)
1 staff nurse (wte)
4 SEN's
1 nursing auxiliary
1 nursing auxiliary (part-time)

2 nurses are allocated for night duty.
Although the policy suggested the value of nursing experience for learners to be gained on this ward, the new GNC ruling is preventing this from happening.

ACCOMMODATION

Generally the comments are similar to those for Bury St Edmunds except that the pass-through cupboards are used as in the policy description, for both supply and disposal of materials and linen to each room.
A second bathroom leading from one of the rooms, has been added and is used as a treatment room.

ENVIRONMENT AND ENGINEERING

The mechanical ventilation (6 rooms) is seldom required as airborne infections are rare, but the ventilation system in any case was not considered to be properly installed. As at Bury St Edmunds, there is a shortage of oxygen and suction outlets and cylinders take a lot of manhandling to reach the outlet required.

OTHER

The Catering system appears to work satisfactorily although 'disposable china' is not used. A specific 'clean' and 'dirty' kitchen system operates for this ward.

This ward was not studied in great detail but the commentary from staff remains pertinent.

In general, the ward is thought to be a useful adjunct to the hospital, and if allowed would be very useful for teaching purposes.

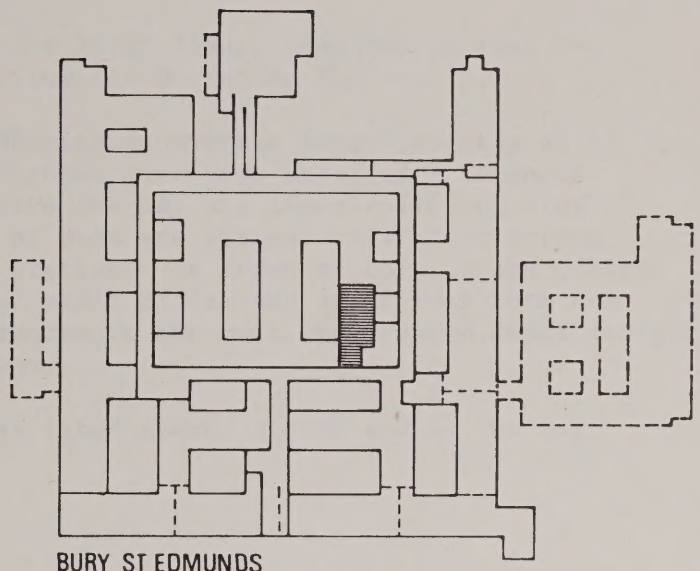
The ward is particularly useful for patients with:

Hepatitis
Tuberculosis
Meningitis
VD

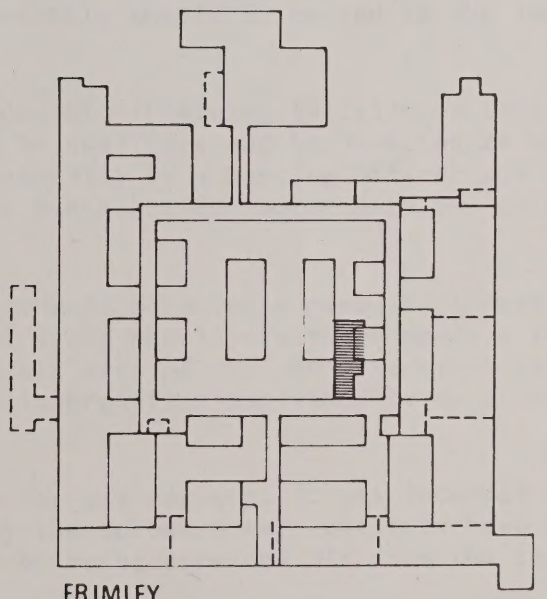
Generally, the objectives have been met in that a good environment for patients and a useful ward have been produced.

Economy in the provision of oxygen and suction outlets and in the tight planning of ancillary washing spaces has caused problems and it is felt that a detailed study of these wards use would be beneficial to planning teams.

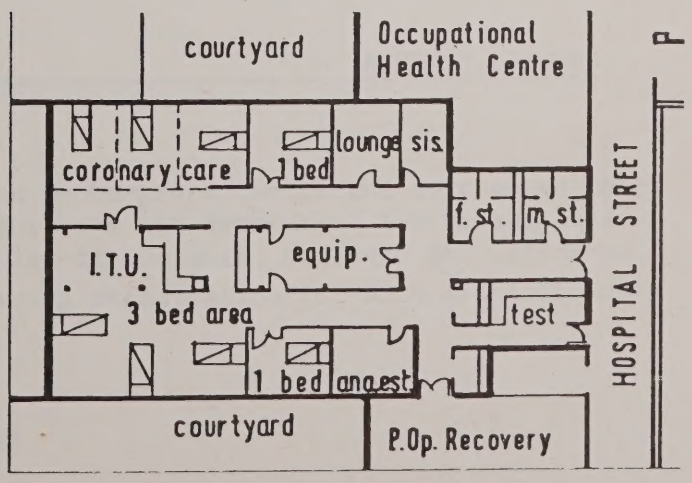
Intensive-Therapy-Unit.



BURY ST EDMUNDS



FRIMLEY



INPATIENTS : INTENSIVE THERAPY UNIT (ITU)

Although the policies list this under 'Treatment and Diagnostic Services', it was thought more appropriate to include ITU within this section as the unit concentrates on particular aspects of nursing care. Appropriate information, however, will be included elsewhere.

LOCATION AND DESCRIPTION

The Intensive Therapy Unit is sited on the first floor, near the patient bed lifts, en-suite with the Recovery Room from the Operating Theatres.

Based on an average occupancy of 50%-70% with an average length of stay of 3-5 days, 8 bed spaces including 2 single rooms have been provided - intended for 50/50 use by those requiring intensive therapy and those suffering from myocardial infarction. These two sets of beds are divided by a glass screen which terminates at the central nurses station. In front of this is the central supplies and equipment store. A medical staff office and staff rest room are provided and on either side of the entrances to the unit are grouped staff changing/WC facilities, testing and disposal rooms.

Overnight accommodation for relatives is sited nearby at the end of the Day and Emergency Unit.

PURPOSE, FUNCTION AND ADMINISTRATION

In providing more space, staff and equipment, this unit was designed to accommodate up to 8 patients requiring continuous monitoring and treatment - an estimated 1%-2% of the total hospital patient workload. Exceptions to admission would only be those patients who more appropriately should be nursed in the Isolation Unit.

Although the unit should serve as an education/training facility, a large percentage of the nursing staff should be qualified and be directed 24 hours/day by a Grade 6 (sister) nurse, and generally by a Nursing Officer who would probably deploy the staff on a flexible basis between post-operative recovery and ITU.

The overall responsibility of the unit should be under a consultant anaethetist, surgeon or physician and junior medical staff should always be on-call for this unit. Treatment, bathing, feeding and all care of the patients would take place at the bedside and the pattern of care is organised individually to a patients needs.

Although the unit can be flexibly used for any urgency, it was intended to function in two distinct ways, which is why the coronary care patients have been given some visual and acoustic privacy by being screened off from the intensive therapy side.

INPATIENTS : INTENSIVE THERAPY UNIT — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The scope of function of the ITU remains unchanged although the unit comes under separate Nursing Officer control from Theatres and Recovery. Two consultants are responsible for overall administration of the unit, one each for Intensive Therapy, and Coronary Care, and the nursing organisation for both sections comes under a sister in charge.

There has been a tendency to admit patients requring terminal care for short periods. This practice is not welcome to relatives or to patients, and is felt by staff to be depressing, and also to be depriving other patients of necessary care. It is policy to hold beds in the 'parent' ward for those patients in the unit.
Ripple mattresses are rarely used because patients are turned sufficiently often: renal dialysis is never used although occasional peritoneal dialysis is carried out.

Very occasionally babies (excluding prematures) are accepted in the unit.

Infection control measures include the wearing of plastic aprons over uniforms but the nursing staff will soon be provided with lightweight uniforms to wear in the ITU, only. Overshoes are not worn, but gowns and masks are worn as and when appropriate.

One housekeeper/cleaner is on duty in the mornings, and some cleaning help is available in the evenings to clean sinks, mop round beds and empty bins. The housekeepers prefer to let the nurses damp-dust around the equipment (for fear of damaging something) and this is acceptable to the nursing staff. Most supplies are ordered by requisition but CSSD, linen and disposables are 'topped-up'.

WORKLOAD AND STAFFING

In 1977 the admissions to ITU numbered 196 (approximately 50% coming via Theatres), and to Coronary Care : 342.
The average length of stay for CCU was approximately 5 days. The figure for ITU was not known, although most patients stay about 2 days: those on ventilators however might stay for several weeks.
Average ITU occupancy is 2 beds (50%).
The staffing-levels have changed little since commissioning and currently stand at:

	Day	Nights
Sister	3	2
SRN/SEN	12	5
Auxiliary	1	-
*Students	3	1

*The students spend 8 weeks in ITU; 6 weeks on days, 2 on nights. The staff feel that they need more full-time SRN/SEN's on night duty.

ACCOMMODATION

Certain points are worth a mention:

1 For relatives the nearest coin-operated telephone is in the Main Entrance, which is considered too far and too crowded for distressed relatives. Also there is nowhere for them to sit in the unit, and they either sit in the corridor or occupy the staff-room. Overnight accommodation in the adjacent ward-link is considered adequate.

2 The open bed area is very crowded when all 3 beds are occupied. Another monitor is needed in order to avoid moving the existing equipment about, which consequently causes damage. This problem will be exacerbated if and when a fire-escape route is created.

3 Storage space is felt to be inadequate particularly for equipment such as IV stands, ventilators and monitors. There is no area available for linen, and a linen trolley and mobile X-ray machine stand in the corridor. Additionally, there is nowhere to store the special turning-bed which is used for spinal and chest injuries.

4 The nurses station has had to be enlarged to provide room for monitors, casenotes and for writing (doctors etc).

5 There is little room for bedside teaching, and a lot of it has to be done in the staff room.

6 The changing-rooms are both used by female staff and are still felt to be inadequate in size.

ENVIRONMENT AND ENGINEERING

Several comments were made - some points are receiving action:

1 The ventilation and heat in the unit (particularly in summer) do not appear to be adequately controlled, and all staff would prefer to have air-conditioning. Some of this problem is caused by solar glare which has necessitated the installation of sun louvres.

2 Compressed air was not originally provided for the ventilators. This has now been rectified.

3 Patient/nurse call systems were not provided in CCU, and are required; and an emergency/attention light rather than alarm has been installed at the nurses station in order to cut down night time disturbance.

4 The medicine trolley supplied in inadequate for ITU and attempts have been made to get 2 additional drug-cupboards installed.

INPATIENTS: INTENSIVE THERAPY UNIT — FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

In Frimley, the ITU comes under the control of a Nursing Officer responsible also for Theatres and Recovery, TSSU and two other Operating Theatres in another 'local' hospital.

A sister is allocated as described in the policies and although the unit was not busy at the time of the survey, when it is under pressure a back up service is provided by temporary special care undertaken in the Day and Emergency Unit. The nursing officer feels that the coronary care beds should be situated in another part of the hospital.

Infection control is a matter of concern as the rate of cross-infection is thought to be high. It is believed that the poor ventilation in the unit has a considerable effect on this aspect.

Neither the Recovery area nor the ITU is supposed to be included in the 'clean' area (according to the policies), but there is a certain amount of confusion because ITU and Recovery staff do not come under the same sister (as was intended).

WORKLOAD AND STAFFING

Although no precise figures were available for throughput and length of stay, it was estimated that an average coronary care patient would stay about 2 days and ITU patients might stay several weeks.

The staffing occupancy for the whole unit was about 4 (50%).

Staffing levels were given as:

Sisters	8	Total
Staff nurses	13	"
Auxillaries	1.5	"
Housekeepers	2	"
Students/learners - occasionally		

ACCOMMODATION

A number of comments about the size of rooms seemed to indicate that all rooms except the disposal room were too small. This had been divided to include a blood gas analysis laboratory (which was now considered too small, also). Particular comments included:

1 The open multi-bed ITU room was crowded with equipment and the only fire exit is through coronary care onto the roof terrace.

2 The changing rooms were both used by female staff.

3 The pantry is too small to prepare meals. (Meals are not accepted from the Main Kitchens because of the difficulty in conforming to set meal times). D and E are luckier in that they can order their meals from the Snack Bar as required.

4 The staff and cleaners rooms are too small - the former having no accommodation for the lead aprons which are now hung in the corridor.

5 The anaesthetists rooms is used overnight for on-call staff, as a doctors office, as an interview room and for teaching. It is thus flexible in use, but is considered too small.

6 The equipment store is too small, and not being ventilated causes heat to build up which is thought to be a danger to rubber tubing on the ventilators.

7 The nurses station is considered 'a disaster' mainly owing to the poor observation obtained, and the lack of space for housing monitors.

ENVIRONMENT AND ENGINEERING

The only comments obtained concerned the poor ventilation (see infection control etc).

By its very nature, this compact unit concentrates into one small area the highest dependency patients (except children and isolation cases) of the whole hospital. Both hospitals designate beds according to the policies and although the average occupancy rate is 50%, this figure could not easily be increased without chaos being caused due to the clutter of equipment and the large numbers of staff moving around the unit.

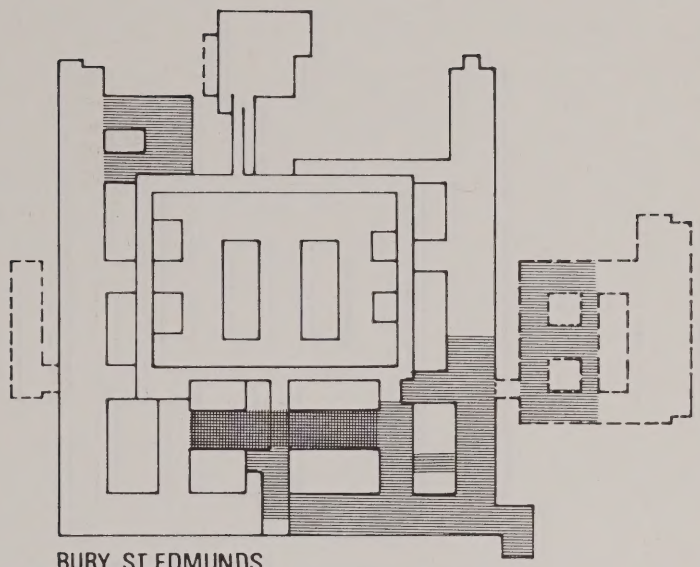
At both hospitals reservation was felt about the advisability of including Coronary Care with ITU patients in one unit, but the medical staff appeared to be happy about the design and location of the unit in general.

Dissatisfaction or concern centred around 3 points:

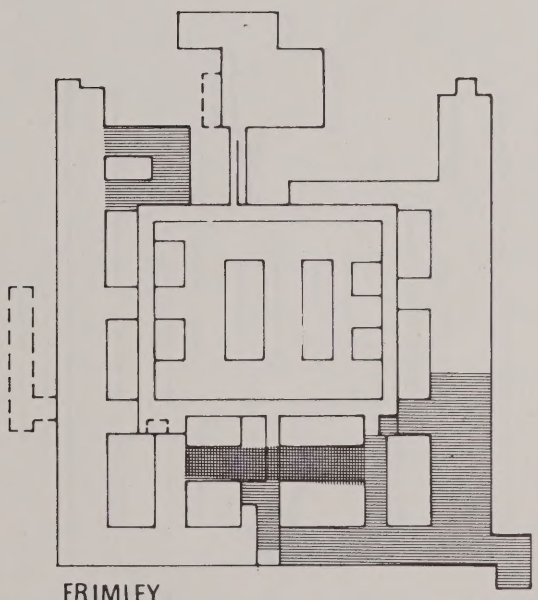
a Poor ventilation
b Poor heat control
c Cluttering of the circulation space and the lack of a proper Fire-Exit

Comments from the engineers at both hospitals pointed to the ludicrous zoning for fire alarms and compartments. Changes are occuring at Frimley, but at both hospitals it was previously impossible to ascertain for example whether an indicated fire (on the control panels) was raging in the staff dining room or in ITU.

Outpatients & Daypatients.

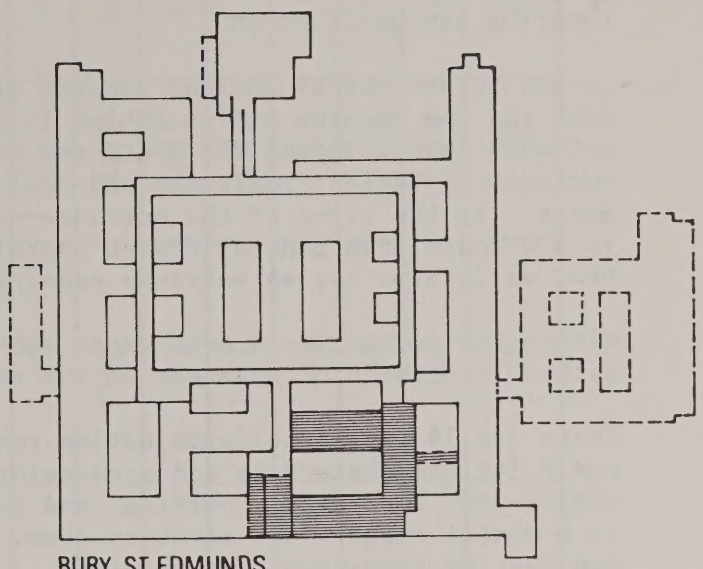


BURY ST EDMUNDS

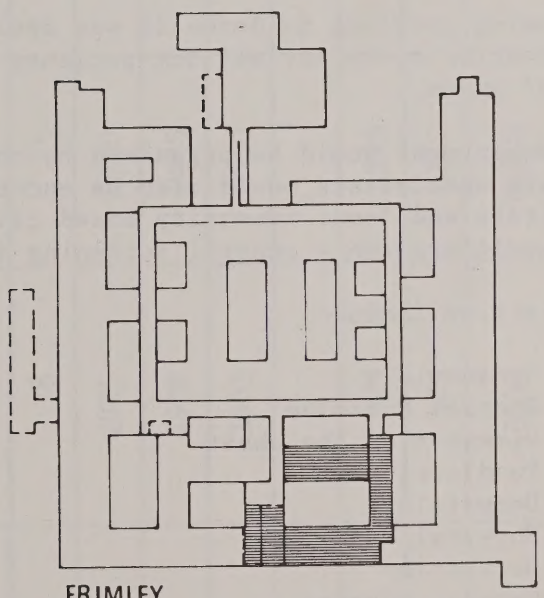


FRIMLEY

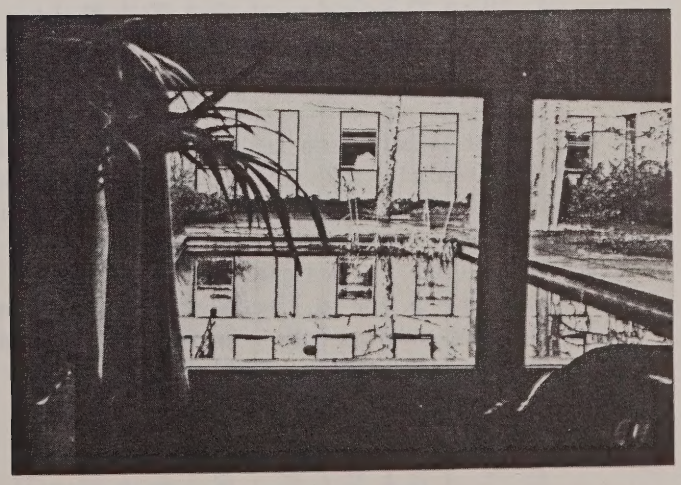
General & Dental, Obs. & Gynae O.P.D.



BURY ST EDMUNDS



FRIMLEY



OUT PATIENTS AND DAY PATIENTS
GENERAL OPD, DENTAL OPD, OBSTETRICS AND GYNAECOLOGY

Out-patients design and organisation is a vast topic, and this study cannot hope to cover it in anything but a brief and general fashion. The information will follow the format of the report, but it is recommended that the subject should be covered by a special study.

LOCATION AND DESCRIPTION

Linked to and run by medical records organisation the main entrance reception desk and the records office behind it are located to the left of the main entrance lobby, facing the doors and the out-patients department. They contain the central patient-registers and deal with all out-patient enquiries and appointments. To the right of the entrance-concourse the out-patients department extends in a U-shape from general OPD to dental OPD and round to obstetrics and gynaecology OPD, which also has an entrance opening off the far end of the concourse.

Within the out-patients department sub-reception and waiting points are situated either in between or adjacent to the consultation/examination suites and offices.

There are 14 consulting/examination rooms for general OPD (including ophthalmology) and 8 for the obstetrics and gynaecology clinics. In addition there are numerous offices for specialist, nursing, and social work and portering staff and there is a dental surgery and recovery room. Clean and dirty utility and urine collection and testing rooms are also provided.

PURPOSE, FUNCTION AND ADMINISTRATION

Following previous guidance it was decided to provide combined consultation/examination rooms for all out-patients clinics and to encourage the flexible use of space.

The department would be organised by the appropriate medical divisions and certain specialists would also be encouraged to use the remaining outlying hospitals and local community based clinics for some of their services. The DGH would provide a general screening function for its catchment area.

Specialties include:

- Gynaecology
- General Medicine
- Diseases of the chest
- Paediatrics
- Dermatology
- Physical Medicine
- Geriatrics
- General surgery
- Orthopaedics and fractures
- ENT
- Ophthalmology
- Dental surgery
- Psychiatry
- Veneral disease
- Regional specialties

Most patients would attend clinics by appointment, usually after pre-registration, and those requiring specific or urgent treatments would attend the Central Treatment Suite, or the Day and Emergency Unit.

The functional size of the unit was based upon a catchment population of 175,000 people and accordingly 72 general, 9 dental and 12 obstetric and gynaecological sessions/week were anticipated.

It was hoped to screen and prevent as many gynaecological patients admissions as possible, but a large number of diagnostic procedures would take place in OPD before admission. Local GP's were also to be encouraged to use the facilities in OPD.

NEW PATIENTS PER ANNUM

	AVERAGE FOR 175,000 POPULATION			WEST SUFFOLK HOSPITAL		FARNHAM GROUP		BEST BUY PLANNING LOADING
	ENGLAND & WALES	EAST ANGLIAN RHB	SW MET RHB	1966	1967	1966	1967	
GENERAL MEDICINE	2220	1740	2270	860	777	1847	1848	2400
PAEDIATRICS	546	330	710	185	219	374	366	550
CHEST	1540	1270	1370	212	185	1140	1155	1200
DERMATOLOGY	1377	1260	1313	578	545	747	747	1000
PHYSICAL MEDICINE	610	514	1320					1000
V.D.	319	274	762	84	71	283	235	300
GERIATRICS	67	78	75	42	28			200
GENERAL SURGERY	3490	2865	3540	1048	1152	4272	4486	4800
E.N.T.	2425	1908	2445	992	993	2163	2240	2700
OPHTHALMOLOGY	2720	1883	2650	937	1053	1347	1372	2000
REGIONAL SPECIALTIES				124	115	351	373	600
PSYCHIATRY	525	525	525	282	253	558	587	750
DENTISTRY	1747	883	3510	460	334	386	415	3000
TOTAL	17586	13530	20490	5804	5725	13568	13824	20500

ORIGINAL PLANNING POLICY OPD ESTIMATES TABLE 2

	New Patients Per Annum	New Patients Per Week	Doctor Sessions Per 100 New Patients	Doctor Sessions Per Week	Room Sessions per Doctor	Room Sessions Per Week	Addi-tional room Sessio
General Medicine	2400	48	25	12	2	24	6 Dietic
Paediatrics	550	11	25	3	1	3	
Chest	1200	24	25	6	2	12	
Dermatology	1000	20	18	4	2	8	
Physical Medicine	1000	20	20	4	2	8	
V.D.	300	6		3	1	3	
Geriatrics	200	4	25	1	2	2	
General Surgery	4800	96	12	12	2	24	
E.N.T.	2700	54	12.5	7	1	7	
Ophthalmology	2000	40	18	8	1	8	
Regional Specialties	600	12		2	2	4	
Psychiatry	750	15		6	1	6	6 P.S
Dentistry	3000	60		9	Surgery plus use of con-sulting rooms	6	
Anaesthetics				4		8	
Teaching				9	1	9	
TOTAL	20500	410		90		132	12
OFF SITE PROVISION				9		Say 10%	
NET TOTAL				81		130	

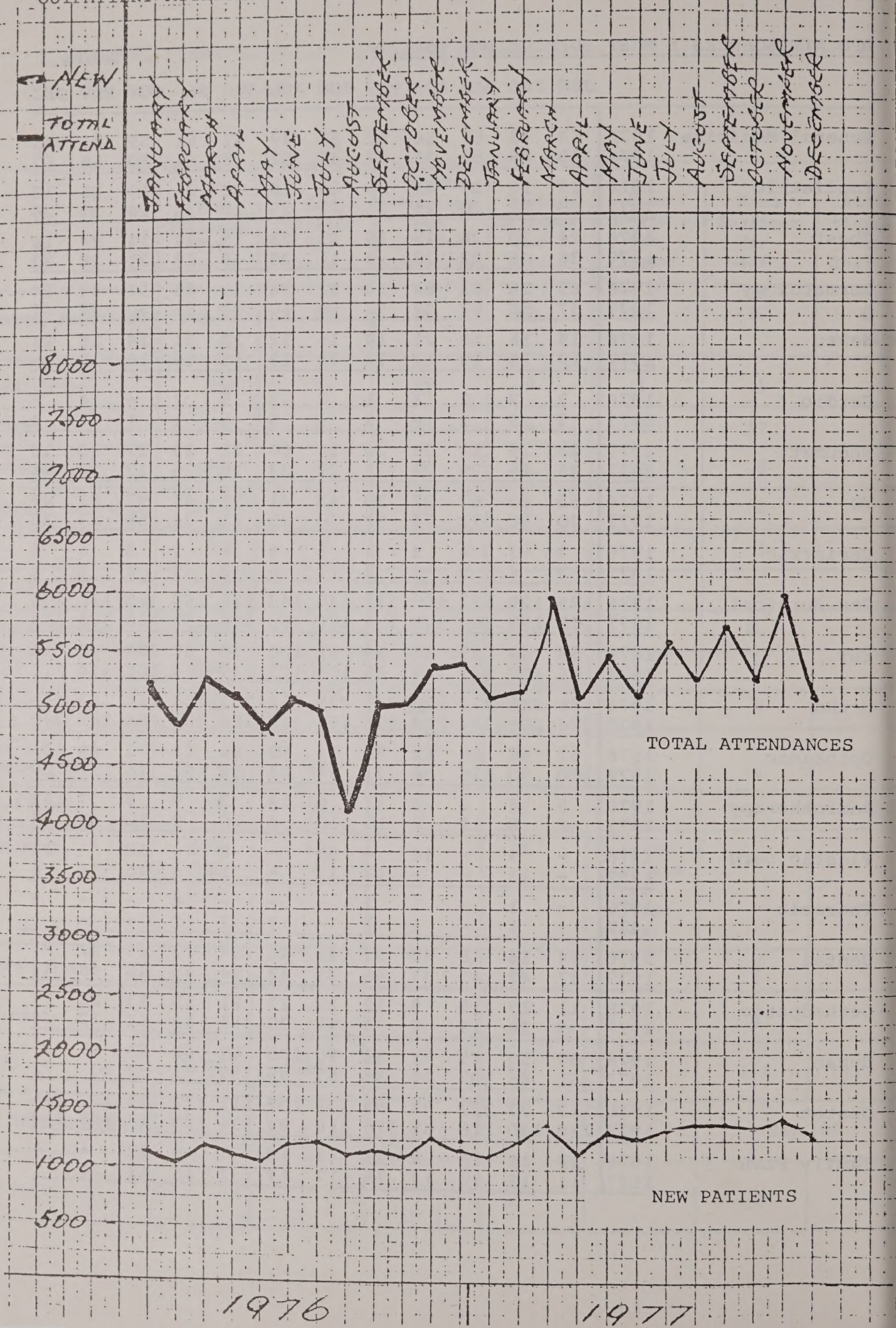
OPD ATTENDANCES : WEST SUFFOLK DGH 1976/7

Table 3

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
General Medicine	1976	63	48	55	54	52	59	49	43	61	55	47	44
	1977	48	48	55	34	62	45	52	48	61	50	55	67
Paediatric	1976	19	15	27	21	33	36	19	22	21	19	26	32
	1977	20	21	20	15	26	13	25	19	26	28	27	26
Chest	1976	24	20	28	19	19	22	23	15	14	14	24	16
	1977	36	26	22	23	29	11	29	49	13	21	28	22
Dermatology	1976	65	26	63	84	29	52	74	53	45	54	43	64
	1977	37	58	82	32	52	58	60	63	85	40	67	41
Neuro	1976	19	18	19	21	14	16	12	13	21	14	16	21
	1977	12	15	19	12	14	21	13	15	19	15	17	19
Cardio	1976	3	2	2	1	1	2	3	5	1	-	4	-
	1977	3	3	2	-	2	-	6	2	1	1	1	4
Rheumat	1976	28	29	13	28	30	26	30	31	25	27	30	18
	1977	25	25	29	23	32	21	33	28	26	17	30	24
VD	1976	63	40	62	32	30	45	41	55	45	57	62	48
	1977	70	60	79	74	52	70	75	81	76	58	69	58
Geriatric	1976	3	3	4	3	3	3	4	-	5	5	6	4
	1977	2	4	5	6	2	2	6	2	5	4	3	3
Gen Surgical	1976	179	129	152	150	142	146	147	128	156	168	136	156
	1977	108	155	169	178	159	176	163	136	182	168	178	153
ENT	1976	53	64	39	68	59	82	100	70	66	104	98	91
	1977	96	107	141	137	88	109	123	139	113	101	114	112
Ortho	1976	186	228	233	228	247	225	236	203	267	241	287	250
	1977	226	208	294	228	276	224	248	288	284	258	245	240
Opthalmic	1976	67	68	86	62	71	78	92	82	73	73	69	101
	1977	100	90	116	56	71	74	88	98	91	76	117	80
Radiotherapy	1976	8	4	4	6	11	6	14	7	7	9	7	13
	1977	2	8	11	8	10	10	8	10	9	10	9	6
Plastic Surg	1976	-	9	-	14	-	25	-	8	-	10	-	11
	1977	-	13	-	-	17	17	-	14	-	15	-	6
Thoracic	1976	-	1	-	1	2	-	-	-	4	-	-	2
	1977	1	1	-	1	1	-	1	2	2	-	-	-
Dental	1976	44	36	48	40	37	42	45	34	22	26	42	27
	1977	37	42	41	37	46	35	43	44	45	48	48	48
Orthodontic	1976	11	15	18	9	15	22	27	21	13	13	22	13
	1977	9	16	19	8	38	41	20	19	13	44	17	6
Gynae	1976	69	59	79	71	63	90	108	87	62	83	95	57
	1977	61	66	107	79	98	59	85	95	91	82	102	72
Obstet	1976	117	97	127	94	98	105	107	111	122	111	135	116
	1977	118	120	116	88	110	118	93	134	122	116	163	110
Family Plan	1976	13	10	13	8	15	4	18	7	9	12	4	4
	1977	11	16	12	14	16	17	17	7	11	11	20	

OUTPATIENT ATTENDANCES : BURY ST EDMUNDS

Table 4



OPD ATTENDANCES : WEST SUFFOLK DGH 1976/7

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
GP	1976	24	22	25	11	9	16	12	10	17	12	25	14
	1977	17	15	13	12	17	10	10	8	15	10	16	13
Psych Child	1976	11	16	5	25	11	23	17	23	22	15	12	27
	1977	21	19	13	27	8	37	17	4	20	11	19	22
Ment H'cap Child	1976	-	-	-	2	-	-	-	-	-	-	-	-
	1977	-	-	-	-	1	1	-	1	2	-	4	-
Psych Adult	1976	14	19	17	14	20	15	12	8	10	18	19	12
	1977	15	15	20	15	23	11	14	12	11	13	26	12
Anaes	1976	3	1	-	3	-	-	-	-	2	-	-	-
	1977	1	1	1	2	-	2	5	6	3	3	-	-

OutPatients seen on Wards

Psych Adults 1976 : 469
1977 : 533

Total OutPatients

1976 : 13452 (New) 58502 (Follow-up)
1977 : 15536 (New) 68591 (Follow-up)

Sessions

1976 : 3614
1977 : 3431

DNA 1976 : Not recorded
1977 : 5192

The nursing staff would come under the organisation of a Grade 7 Nursing Officer and a small number of sisters with appropriate specialised training. A medical records officer would be responsible for the organisation of reception, appointments and records in conjunction with the medical and surgical divisions, the latter being ultimately responsible for providing the out-patient service.

PURPOSE, FUNCTION AND ADMINISTRATION

In this area the population has remained comparatively stable, and statistically the numbers of patients attending the department are not greater than the planning figures.

The Best Buy planning load was 20,500 new patients/year (1967), the actual attendances were 15,536 (1977) new patients, 57,977 total attendances and 3607 clinic sessions. In spite of this the department is crowded and considerable reallocation of rooms is necessary.

New clinics include:

Neurology
Cardiology
Thoracic surgery
Plastic surgery
Psychology
Ophthalmic (contact lens, community optician)
Radiotherapy

An increasing number of treatments are done in the department.

Administration:

A nursing officer is in overall control of the department as well as for Accident and Emergency. A sister co-ordinates the work and facilities in conjunction with other professional and technical staff. One other sister looks after the opthalmic clinic and has her own staff nurse and nursing auxillary.

Organisation of clinics:

Clinic receptionist are used as recommended (policies), however, the clinics are run differently, in particular the medical clinics where delays in dressing hold up the clinics (partly because of the age of the patients)

More rooms/specialist are used than were recommended, eg one physician has 3 or 4 rooms (not 2) and the surgeons have 4 rooms and 4 nurses. Consequently there are difficulties in fitting in more clinics.

The physician needs a dietician for most of his clinics, the dietician sees patients every day and has no room allocated. Physicians think that the consulting/examination room system is wrong and would prefer 1 consulting and 2 examination rooms en-suite.

ACCOMMODATION, DEVELOPMENT AND CHANGE

ENT Clinic:

(Total attendances = 2769 new patients = 894 Audiometry = 855 hearing aids = 1997).

A new audiology extension has been built containing 2 audiology rooms, speech therapy and secretaries offices.

The extension takes up most of the ophthalmic sub-waiting area as well, and is causing problems with ENT clinic requirments for waiting for patients with nose-problems, or for recovery.

Ophthalmic Clinic:

(Total attendances = 7060 new patients = 922 orthoptics - 1388 sight testing = 557).

The facilities for this clinic are not considered satisfactory. 'The so-called opticians room is like a broom-cupboard', and the orthoptists room is not suitable for 2 people to work together. The opticians room is wholly unsuitable for refractions - for which it was not meant - and the room for refractions is very narrow and should, in fact, have the same facilities as are normal elsewhere.

Many more electrical points are required for all the requipment used. The test type was not allowed to be screwed to the wall as it was too heavy. 'It is extraordinarily restricting in how one can use the room'.

Storage and lockable rooms are needed for expensive and delicate equipment.

The number of patients is increasing and there is now inadequate waiting-space.

Dental Clinic:

(Total attendance = 1554 new patients = 443).
The Central Treatment rooms work well for minor oral surgery under local anaesthesis, which is fortunate as the dental surgeries are too small.
The dental surgery which was modified at commissioning stage by the consultant dental surgeon now works because he advised on the correct work-flow and positioning of equipment, but it is too small and noisy; it should have been twinned with a second surgery so that the consultant could work with a registrar or house officer. The requirements for an efficient dental service in the Bury St Edmunds area, according to the dental surgeon were:

1 2 fully equipped dental surgeries.
2 An office/interview room.
3 A small dental laboratory with storage space for orthodontic models and equipment.
4 An enclosed recovery room,
5 Provision for the accommodation of dental inpatients in the ward block.
6 The use of day-beds.
7 Situation of the dental clinic within easy access of the day-beds and Operating Theatres.

It is considered that the accommodation provided for Kings Lynn although 'more adequate in layout, is unsatisfactory ... and it is obvious that no-one has learned any lessons ... from Bury St Edmunds'.

Dermatology:

(Total attendances = 1904, new patients = 652).
3 rooms are used for every clinic; the treatment room is used for biopsies etc and the two consulting/examination room for dressings. This busy clinic is not mentioned in the operational policy.

Psychiatry:

(Total attendances = 1545 + 246 children, new patients = 178 + 207 children). It is not possible to fit in more OPD sessions here, although they are required. At present others are held in the department. In the policy it is suggested that facilities for child psychiatry should be provided in the psychiatric unit; however, an area for a play-therapist and an educational psychologist is required in OPD, where special equipment, sand and water could be used.

Special (VD) Clinic:

Total attendances = 2406, new patients = 580 (1976) 882 (1977).
The original planning figures estimated 300 new patients/year.
There are problems with the time allowed for the clinics, (they go on from 09,00 hrs to 19,00 hrs) and there are often 50-60 people at a clinic, sometimes 70.

Space is required for records, registrations, clerical assistance, and dispensing. The clinic is too large, and the slides have to be prepared in the sluice room.

Gynaecology Clinic;

(Total attendances = 3148, new patients = 1050).
Clinical facilities are shared with the ante-natal clinic, but the layout of the clinic is not liked because of the lack of privacy and confidentiality. 60% of patients go to the laboratory for vene puncture- this works well, but some patients require help from portering staff.

ECG's:

There are problems about lack of facilities. A base is required in OPD. Patients require a separate area for undressing and at present there are great delays and patients are waiting too long. Another treatment room is required; two couches have been put into one room which is unsatisfactory, and the Central Treatment rooms have to be used (this is recommended in the policies).

Reception and Waiting:

There is not suficient sub.waiting space available. Space for 60 was split into 3 or 4 areas, which means that relatives, friends and patients may have to wait in the entrance area. This makes it time-consuming for staff to find and assist them, particularly as many are old and disabled.
The courtyard was used as additional waiting space, but this had to be prevented owing to overseeing and overhearing clinics.

Social Workers:

They have now moved to the Administration block leaving the rooms available for other essential people.

Chiropodist;

(Total attendances = 945 new patients = 54).
The room provided is considered too small.

Supporting Services;

There is a general lack of storage space.
The clinettes are not liked - other types are now more functional as the system of use has changed.

ENVIRONMENT & ENGINEERING

1 Ventilation - the lack of air - is a problem, particularly in the waiting areas where patients have been know to faint.

2 Nurse/confidentiality is almost impossible for personal communications between nurses, doctors and patients.

3 Access through the department to Physiotherapy is not liked, and is tortuous.

OTHER

Liaison with the community nursing officer is excellent. The house-keeping system should be extended to OPD as it is found to be very suitable.

Generally the design of the OPD is not liked. There is a gross lack of rooms, and of privacy. The layout of the department seems to necessitate the use of more porters.

Particularly the disposition of the sub-waiting areas opposite consulting/ examination rooms is considered far from ideal.

OUTPATIENTS AND DAY PATIENTS FRIMLEY
OUTPATIENT DEPARTMENT

PURPOSE, FUNCTION AND ADMINISTRATION

The population increase from the planning estimates of 175,000 to 260,000 has cast considerable doubts that a fully covering out-patients service is provided to the catchment community. Patients are having to go elsewhere. Farnham hospital does 32 sessions instead of the planned 9, and Frimley Child Centre runs the paediatric clinics.

The Best Buy planning 'load' was for 20,000 new patients/year. In 1977 Frimley Park had 18,632 new outpatients, but a total of 66,274.

In 1976 the Farnham group had 13,827 new outpatients and in 1977, 26,701. Expansion is already required as nearly every clinic is thought to have increased.

There are new clinics for:

Genito-urinary
Oral surgery
Pain clinics) held in Clinical Investigation
Anaesthetic clinics)

Many more investigation and treatments than were envisaged, are being done in OPD, and the nursing officer feels that the extension of treatment is now a major trend. Treatments carried out regularly include:

Sigmoidoscopies (12 or more/clinic)
Rectal biopsies
Proctoscopies
Injection of haemorrhoids
Cryotherapy of haemorrhoids
Injection and bandaging of varicose veins
Breast biopsies and smears
Incision of myobeian cysts
Lachrymal probing
Centrum washouts
Ear syringing
Cauterisation to nose
Cryotherapy (Dermatology clinic)
Dressing and removal of sutures
Injections (Dermatology, Psychiatric, Diabetic patients)

Dermatology Clinic:

1977 total attendances = 3773, new patients = 1174. This is a busy clinic which required use of the treatment rooms. It is not mentioned specifically at all in the Planning Policies.

Administration:

The organisation of the department is as suggested in the operational policy, with the nursing officer co-ordinating the work and facilities in conjunction with other professional and technical staff.

Organisation of Clinics:

As far as possible the planned procedures are followed. (The patient remains in one room throughout the consultation and as many procedures as possible are carried out in the consultation/examination room. The doctor would move from room to room.)

For fast-moving clinics (such as surgical clinics) the system is impossible and patients are prepared in the room prior to the doctor moving from room to room. If a return patient needs to undress, he is asked to to this and wait for the doctor.

Only 2 consultation/examination rooms were allocated to each consultant because of the shortage, and often 4 rooms are required; 2 for the consultant, 1 for the registrar and 1 for the house officer. Endless juggling takes place to allocate sufficient rooms. In one surgical clinic 70 patients are booked and it has been suggested that 2 examination rooms to one consulting room would be preferable.

Staffing Pattern : Procedures

The receptionist for each clinic holds the notes and the patients go to her. The nurse then takes the notes when called, weighs the patient and if necessary takes a urine sample, and at the same time checks that all the notes are available. (Recently receptionists have been wanting to enclose X-ray photographs with the notes).

A nursing auxiliary attends in the room with the doctor, to assist with each patient. A trained nurse looks after the whole clinic. More trained nurses would be preferred to nursing auxiliaries. The usual staffing figures allow for 1 auxiliary and 1 trained nurse/2 doctors (less than in the policy). This is worrying staff because of the increased workload, but students have recently been allowed to help in this department.

WORKLOAD AND STAFFING

(Clinic numbers are shown for specific clinics).
The commissioning policy suggested 1 nurse to 5000 patient attendances which would result in 13.25 wte. In actual fact there are 13.44 nurses, but this is still insufficient to allocate one to each consulting room.

ACCOMMODATION, DEVELOPMENT AND CHANGE

ENT Clinic:

(Total attendances = 5824, new patients = 2011, audiometry = 2713 attendances, hearing aids = 2328 attendances).

Facilities are minimal and the treatment room always has to be used. The clinical room is used as a consulting room quite often because there are 2 doctors who require 3 rooms. Patients need somewhere to wait under nurse observation with cocaine probes in their nostrils. There is not room for the number of tests being carried out. A houseman in the clinic does cauteries and ear-syringing.

Numerous children wait for ENT examinations and their sharing of the ophthalmic waiting area is not satisfactory.

Audiometry:

There are 2 audiometricians and their facilities are not adequate, as there is only room for one. Often 3/4 of a clinic may require audiology tests and a lot of time is spent waiting. There are complaints about noise and because of the lack of ventilation an air-vent was put in the door - this now allows excessive noise to enter from the waiting area.

Ophthalmic Clinic: Reception/telephone

Orthoptist Optician C/E slit lamp C/E

(Total attendances = 6,644, new patients = 1651).
Emergency and ward patients come to the clinic at any time as this is where the only slit-lamp in the hospital is kept. The eye-room cannot be used for other purposes and there is no external access to the dark-room.

There are 2-3 consultants and often the opticians room has to be used. The 2 orthoptists find it very difficult to work in their small room at the same time.

There is no Optician, so that room is used for eye-clinics, special clinics, eye prosthesis fittings, plastic surgery clinics and it is sometimes used as a sisters office.

Generally the rooms are too small and they need to be replanned. They suffer from overheating and distracting noise.

Dental Clinics:

(Orthodontics = 757 attendances).
The policy states that the dental surgeon might see the patient first in a consulting room and subsequently take the patient into the surgery. If this occured, they would have to walk through the recovery area to reach the surgery The recovery room should have been placed on the other side of the surgery.

Dental laboratories are not used and no dental X-ray was provided (although mentioned in the planning policies).

Psychiatry:

(Children total = 114, new attendances = 40, adult total = 1935, new attendances = 413).
6 sessions plus a child psychiatric session are held. An adjoining room for a psychiatric social worker is required, only 2 rooms are available to the consultant and registrar.

Special (VD) Clinic:

(Total attendances = 1995, new attendances = 589).
Three rooms are used twice/week. One ENT room has to be used and so does dental recovery room. Female clinics are done in the same area, not in the Gynaecology clinic as planned, because of staffing difficulties and preparation of slides.

The ENT room is used as a consulting-room, the adjacent room is used for female examinations and another room is used for male consulting/examinations. The dental recovery room is used for a special problem clinic.

Slides have to be prepared in the sluice-room, where the microscope and all the slides and records are kept. A health-visitor also uses this room (she does contact chasing) and has to do all her paper work there. No store was provided.

In spite of the booked minor operations (biopsies, vasectomies and dermatological dressings) in the Central Treatment rooms, the number of treatments required is increasing and the one room is inadequate.

The system for collecting urine samples is not satisfactory. (Refer to Woking).

ECG's:

(Total attendances in OPD = 546)
There are 3 ECG technicians who are based in the link corridor to Wards F3/4 in the housekeeper's office. Patients often have to go there, but sometimes the dental recovery room is used. There are problems with the taking of ECG's.

Dermatology Clinic:

(Total attendances =3773, new patients = 1174).
There is one consultant and one clinical assistant. Each requires 2 rooms. The clinical room is used for all the long dressings 3 sessions/week.

A lot of microscope work is done and photography, this has to be locked up. Having to send out for a photographer is a problem and sometimes the rash has gone before the photographer is available.

Dietician:

There was no room for the dietician. She sees between 50-70 outpatients/week. Patients have to be seen in the waiting area and can obviously be overheard - this is unsatisfactory.

Reception and Waiting:

The distances are the problem here. Sub-waiting areas are too small and some patients have to wait in the main concourse. Time is spent looking for them.

Sub-waiting outside the consulting rooms is not liked because of the confidentiality/ noise problems.

Patients do not like being weighed in this area, and separate room should be provided, or alternatively every consulting/examination room should have its own scales.

Social Workers:

As OPD is so short of space, it is considered that social workers should be sited elsewhere. They use 4 rooms, 2 of them for a clerk and a secretary.

ENVIRONMENT AND ENGINEERING

1 Ventilation is generally poor and the sub-waiting areas become overheated with little air-flow.

2 Noise and lack of privacy/confidentiality is a problem between consulting rooms and between them and the waiting areas.

3 The sub-switchboard (telephones) has 6 extensions and only 1 line. 2 lines are needed. This is being changed as delays in clinics are occuring.

OUTPATIENTS AND DAYPATIENTS CONCLUSIONS

OUTPATIENTS DEPARTMENT

It appears that in neither hospital has the outpatient department been a total success. The juggling of rooms in order to allow for more specialties is extremely difficult - for example, a change of session must take into account the time-table of operating sessions and whether they can be altered.

The number of rooms allocated to each doctor is inadequate and really causes difficulties.

The increased amount of training/teaching must be accommodated, as must the wide age-range grouping of patients.

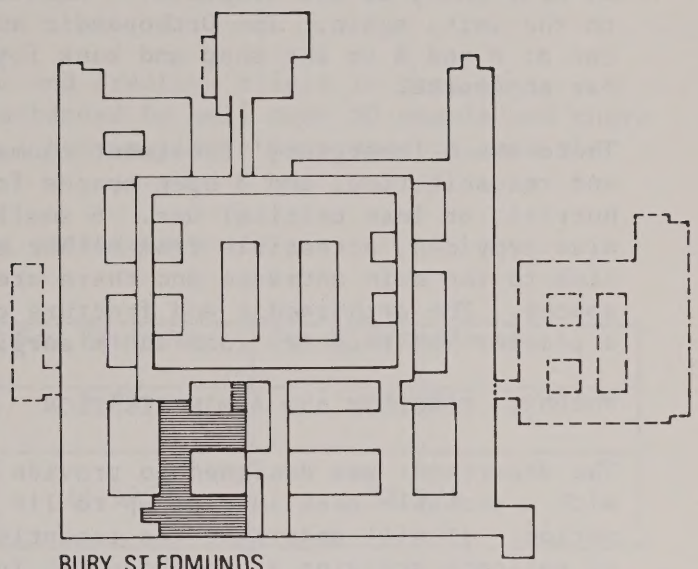
An increasing number of treatments in OPD is certainly casuing a problem with the present accommodation and layout.

Detailed workflows need to be done for ENT, ophthalmic and dental clinics.

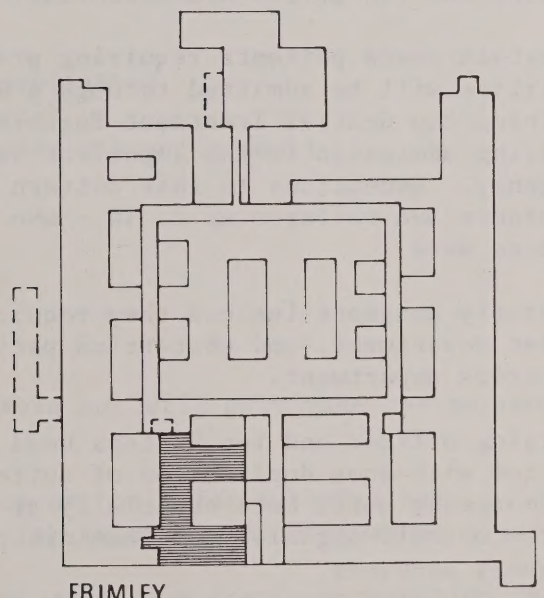
Dermatology needs more facilities than were planned and in both hospitals so does the special (VD) clinic, whose attendances are far higher than expected.

Economy of space provision in this department was probably the most unwise policy. The study of these two outpatient departments requires more time and expert statistical analysis. It was not possible to see all the people involved in they day to day work of the departments.

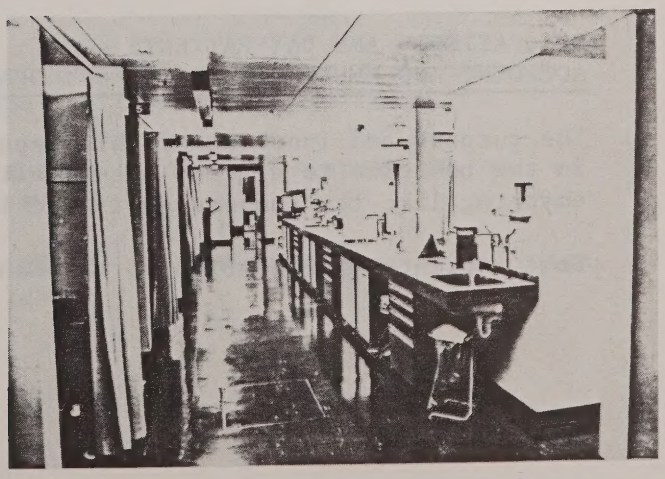
Accident & Emergency Dept.



BURY ST EDMUNDS



FRIMLEY



OUT-PATIENTS AND DAY-PATIENTS
ACCIDENT AND EMERGENCY DEPT : ORTHOPAEDIC AND FRACTURE CLINIC

LOCATION AND DESCRIPTION

The Accident and Emergency department, at the front of the hospital is situated next to and on the left of the main entrance, with its own entrance (the only 24 hour entry to the hospital). Medical Records leads off the reception area to the left, again. The Orthopaedic and Fracture Clinic crosses from the far end of A and E to the shop and bank foyer at the end of the entrance/snack-bar concourse.

There are 5 'emergency' treatment rooms, 3 of them equipped for minor surgery and resuscitation, and 3 open spaces for treatment are also provided for hurried, or less critical use. 6 smaller examination/treatment cubicles are also provided, accessible from either end. There is a patient waiting area link to the main entrance and there are a number of rest rooms and ancillary spaces. The orthopaedic and fracture clinic contains 6 examination cubicles, a plaster and recovery room and a surgical appliances fitting room.

PURPOSE, FUNCTION AND ADMINISTRATION

The department was designed to provide for the estimated 175,000 population with a probable peak load of up to 110 new and return patients in a 3-hour period. It will undertake the reception, resuscitation and primary treatment of patients arriving at the hospital in need of immediate admission, and will also accept those people needing hospital services urgently as a result of minor injury or illness. Close links with GPs, first aid stations, ambulance services and the police are essential.

In certain cases patients requiring preparation, treatment, and recovery facilities will be admitted through A & E to the Day and Emergency unit adjoining the Central Treatment Suite on the first floor. Admissions at night requiring admission to the inpatient wards will also be sent up to Day and Emergency. Exceptions to this pattern of admissions where applicable will be infants and children up to 14 - who will go respectively to SCBU or to the Children Ward.

Psychiatry patients (unless they require resuscitation) will also go straight to that department, and obstetrics patients will proceed direct to the obstetrics department.

A nursing officer and two sisters head the nursing organisation of A & E services with some duplication of duties extending to admissions to the Day and Emergency ward, more especially at night. There is a consultant responsible for the overall organisation, administration and provision of accident and emergency services.

OUT-PATIENTS AND DAY-PATIENTS
ACCIDENT AND EMERGENCY DEPT : ORTHOPAEDIC AND FRACTURE CLINIC

BURY ST EDMUNDS

The purpose and function of this department obviously follow what was written in the policies to a great extent although the department does not peak at anything like the numbers envisaged in the policies.

Some patients are referred to the Central Treatment Suite where necessary.

Post anaesthetic recovery can be accommodated in the department next to the plaster-room, but if the department is busy the patients are sent up to the Day and Emergency unit to recover - all patients requiring observation or needing to recover are sent there at night.

A number of patients using the department include no-fixed-abode/ social problems, drug overdoses, alcoholics, tinkers and gipsies.

WORKLOAD AND STAFFING

One problem occurring in the Orthopaedic and Fracture clinic is that it is too small. Some clinical sessions are attended by well over 50 people and there is too little space for them to wait in. Many patients have escorts, and the rate of throughput is not fast.

Figures for 1976 indicates the following attendances :

	New Patients	Total Attendances
Orthopaedic and Fracture Clinic	2,831	8,081
Accident and emergency	13,993	22,371

The peak attendances in A & E are not known.

Daytime staffing to cover both shifts is 10 nursing staff; at night the staffing is :

1 Staff-nurse (additional help available)
1 Doctor (on call - sleeps in dept)
1 Radiographer (on call - sometimes sleeps in dept)
1 Receptionist (up to 11 pm)
1 Porter

ACCOMMODATION : ENVIRONMENT ETC

Numerous points were made:

1 The resuscitation room is reasonable but will only take one patient at a time.

2 The 'clean' treatment room is used not only for suturing but additionally for skin-grafts and for insertion of Steinmanns pins.

3 The 'dirty' treatment room is used also as a fracture-reduction theatre - it is too small but could be enlarged by removing the scrub-up area, which is not used.

4 The plaster-room requires an extract system: there are problems with the dust and the plaster technicians are threatening to leave.

5 The corridor of the orthopaedic/fracture clinic is regarded as too narrow - 2 people cannot easily pass.

6 The 'burns 'room needs a window blind due to glare and poor orientation - particularly from afternoon sunlight.

7 An appliance - workshop has been added in the courtyard, adjacent to the orthopaedic consulting room: an appliance fitting room has also been included - these facilities are very much appreciated.

8 The cleansing room is rarely used for 'industrial grime' and has been adapted for use by elderly people who have not been able to wash themselves for a long period of time.

9 The public waiting area at the front of the unit becomes overcrowded at peak periods owing to the large number of relatives accompanying patients. When the access to the cubicles is used, it is also possible to see patients on the examination couches - this is not satisfactory.

The other problem is that 'reasonably well' patients waiting in this area are to a large extent unobservable. They can become unwell during their wait, and the nurses (who are now aware of the problem) have to frequently come round, if the cubicles are in use, to check on them.

10 The staff do not like using the childrens room because it is too small and has no outlook - the staff are trying to have it decorated and think that refurnishing and refitting it would go a long way towards preventing a child feeling he was being shut in - at present this makes the children distressed.

It is thought that perhaps the policy was wrong - instead of 'shielding' the children so much from noisy or un-sightly patients, it would have been more satisfactory to provide correctly sited and designed patient accommodation.

11 The location of the switchboard at the medical-records end of the department brings a lot of 'unnecessary' traffic through the department.

12 The sisters office is regarded as being too far from the treatment area and does not allow sufficient observation.

13 The treatment cubicles are bedevilled from inadequate flexibility of movement, by the awkward positions of the pillars. It is suspected that couches were put in the cubicles because of the real difficulties of manoeuvering trolleys (which would have been preferred).

The positioning of the columns almost within the small cubicles is ludicrous

14 The wash/flush sink in the sluice room is considered far too near the area where wounds are being dressed. It is also considered a fallacy that a bed-pan washer or disposal unit should not be required .... 'the first thing people want to do when they're nervous is _____ ...'

15 The positioning of the central bench unit creates congestion for nurses passing each other, and for guiding unsteady patients to or from cubicles; there is no possibility of all-round movement for staff in the cubicles, and the lack of a gap in the central unit impedes staff moving across the treatment area.

16 Finally, the fixed operating-theatre light in the 'emergency' room is considered as over indulgent provision when a mobile light would have been preferred.

OUT-PATIENTS AND DAY-PATIENTS FRIMLEY
ACCIDENT AND EMERGENCY DEPT : ORTHOPAEDIC AND FRACTURE CLINIC

PURPOSE, FUNCTION AND ADMINISTRATION

This department fulfils the functions described in the planning policies, dealing only with genuine A & E cases. 'Casual' users are very rare. It 'peaks' at levels much lower than those envisaged in policies and in many respects is underused.

The department is suitably linked to the Day and Emergency unit and comes under the control of the Nursing Officer responsible for:

A & E
Orthopaedic and Fracture clinic
Day and Emergency unit
Orthopaedic beds

WORKLOAD AND STAFFING

The area served by this unit has vastly increased from the 175,000 population given in the policies. At present it is approximately 260,000 people.
The 1976 attendances to unit were -

	New Patients	Total Attendances
Orthopaedic and Fracture Clinic	1512	6926
Accident and Emergency	25,000	?

The total attendances in A & E were not given.

The staffing figures were given as:

3	sisters	(full time)
3	SRN	(full time)
2	SRN	(part time)
2	SEN	(full time)
5-8	learners	
1	plaster technician	(just appointed)
1	consultant	(A & E)
3	consultants	(Orthopaedic and Fracture)
4	house-officers	

ACCOMMODATION : ENVIRONMENT, ETC

The accommodation was considered very good on the whole, with only small points marring what is otherwise an enjoyable working environment.

Comments include:

1 The resuscitation room is the wrong shape being rectangular rather than square and it can only accommodate 1 patient at a time.

2 The special treatment rooms are used very little except for occasional general anaesthesia, and most procedures are carried out in the treatment area.

3 The plaster-room seems satisfactory and reductions can be carried out there under general anaesthesia.

4 The cleansing-room is considered invaluable and is frequently used for gastric lavage for overdose cases.

5 The housekeepers base is considered unnecessary as the department only requires cleaners.

6 The disposal room suffers from waste piling up and over-spilling into the corridor. Collections are in the morning and evening only, and perhaps a midday collection would ease this problem.

7 The central work bench in the main treatment area impedes work-flow around it, and should have a break to allow proper movement across the area. In princple, however. it is well liked. The sinks in this bench are poorly related to the cubicles and cause the splashing of papers and notes which have to be carried out here because there is no other worktop/desk nearby.

8 The present location of the drugs cupboard in the clean utility room is considered 'too remote' from the treatment areas.

9 The cubicles are considered too small, and the columns-placed almost inside and in the middle of them - seriously impede the work of the nurses.

10 General the whole department lacks shelves.

OUT-PATIENTS AND DAY-PATIENTS CONCLUSIONS
ACCIDENT AND EMERGENCY DEPT : ORTHOPAEDIC AND FRACTURE CLINIC

Whilst the catchment area population figures at both Bury St Edmunds and Frimley have risen beyond those estimated in the Planning Policies - in Frimley's case dramatically - the impact on this department has not been anything like as heavy as expected - the 'peak' numbers being far less than those estimated.

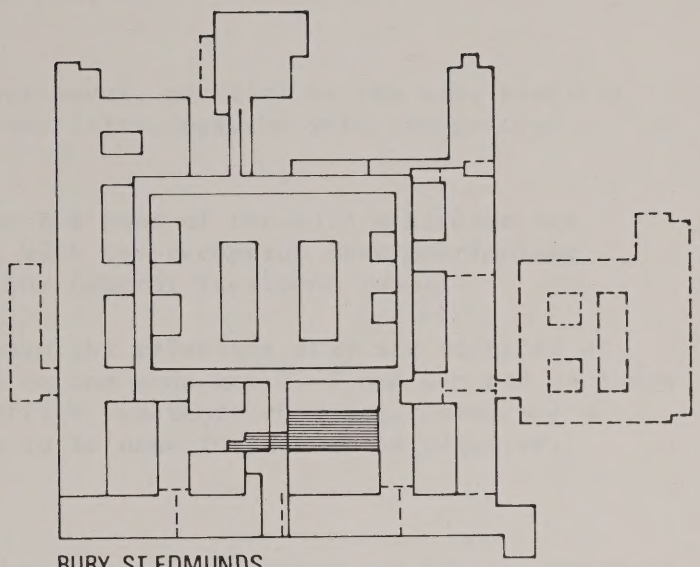
If such 'peak' figures had been approached it is highly likely that the design of the cubicles area in particular would have seriously impeded the capacity of the department to cope. As it is, apart from the occasionally overcrowded orthopaedic and fracture clinic, the department is virtually empty for large periods at a time and the excellent provision of the Day and Emergency unit probably contributes to this.

The functions of many of the rooms have been adapted or changed and in general they provide all the flexibility required. However, the layout of cubicles in relation to columns in the general area is poorly planned - this is a great pity - there are too few fittings and shelves, and the overall observation and supervision around and through the department is not entirely satisfactory.

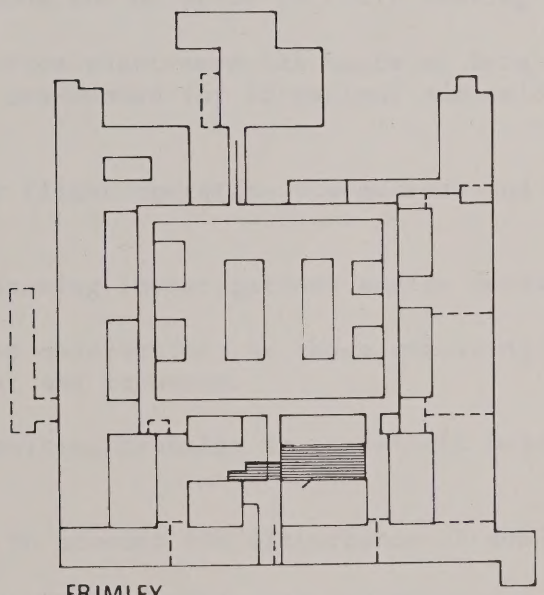
The comments in the ACCOMMODATION : ENVIRONMENT sections should be considered to see where structural or fitment improvements could be made.

A report by Dr Kuck and Dr Hind, DHSS Feb: 1975 on a visit to Frimley Park Hospital also contributes to the comments made here.

Day & Emergency Unit.



BURY ST EDMUNDS



FRIMLEY

OUT-PATIENTS AND DAY-PATIENTS
DAY AND EMERGENCY UNIT

This unit is an innovation in the Best-Buy hospital and is particularly related to the Central Treatment Suite. However it serves a dual function, and in its capacity as a link unit between A & E, OPD, patient reception, and treatment or ward areas it is included here as an outpatient and day patient facility.

LOCATION AND DESCRIPTION

The 20 bed unit is located at first floor level, parallel to the main hospital street, adjacent to the main staircase and lifts, ensuite with the Central Treatment Suite.

The nurses station and reception desk at the head of the main staircase are separated by supply and disposal rooms, with the reception desk overlooking a single room and the waiting lobby to the Central Treatment rooms.

Two single rooms also to be used for overnight relatives stay are situated at the far end of the unit, and in between on one side are 2, 3 and 4 - bed enclosed wards. Opposite them are the sisters office, patients changing rooms, and a large open waiting/recovery area - also to be used for dining as required.

PURPOSE, FUNCTION AND ADMINISTRATION

For emergencies on disaster scale, the unit would be cleared and devoted entirely to such needs. In its normal capacity the unit provides a 'float' of holding, preparation or recovery areas with observation, for patients prior to their despatch to treatment in-patient accommodation or prior to their leaving hospital.

The purpose of the unit would be to provide short-term (24 hours or less) care for various categories of patients not pre-booked for in-patient admission, they include:

1 Patients attending for day surgery (light operative procedures) and day care.

2 Out-patients detained for time-consuming investigations and/or recovery

3 A & E admissions requiring extended observation, or those requiring more than minimal preparation, treatment and recovery.

4 Overnight admissions from A & E awaiting transfer to in-patient beds on the following day.

The last category is included in order to prevent the disturbance of admissions to any ward at night.
'Progressive patient care' will not apply and staffing and bed-allocation will be organised from day to day as the requirements are made known.
A sister and one or two junior nursing staff will normally run the unit during the day, and at night an expected minimum of two nurses will be on duty.
The unit comes under general jurisdiction of a grade 7 nursing officer.

OUT-PATIENTS AND DAY-PATIENTS
DAY AND EMERGENCY UNIT

BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The Day and Emergency unit at Bury St Edmunds very much serves its purpose as a 'float' unit and in addition to its daily and nightly functions also acts as a post-operative recovery unit for night time operations. This enables the recovery area to be left as an unstaffed through-route to ITU (where necessary).

A large number of surgical and orthopaedic patients are treated as day-cases, using this unit, but despite this the unit is hardly ever at full capacity and is thus able to act as a true 'float', for example for wards which are often at capacity, and for patients who need 24 - 48 hours of care on a semi-hotel basis. This is particularly useful in such a rural area where transport late in the day is long and difficult and perhaps troubles the patient. Breast lump and cystoscopy patients are often kept here for 24 hours.

The unit comes under a Nursing Officer responsible also for the Central Treatment Suite, the Surgical and the Orthopaedic wards.

WORKLOAD AND STAFFING

The occupancy of the unit varies radically from 0 to 15 patients at night, a majority of whom are despatched home or to the wards befor 8 o'clock in the morning. As has been stated the unit can be very flexibly organised for day cases who develop problems and need to be kept in overnight.

It has been found sufficient for the majority of the time to staff the unit with 1 SEN and 1 other nurse.

ACCOMMODATION : ENVIRONMENT ETC

Although the unit is provided with 20 bed spaces, the 2 single rooms are only used for doctors or relatives overnight-stay accommodation because it is felt that the rooms are unsuitable for sedated patients, or for patient-observation.

Other comments were generally complimentary and there seem to be no environmental problems.

OUT-PATIENTS AND DAY-PATIENTS
DAY AND EMERGENCY UNIT

FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

The Day and Emergency unit at Frimley is very much appreciated and appears to be very busy.

All overnight admissions are accepted in the unit and although most patients are cleared to the wards or to home first thing in the morning some accident cases - particularly head injuries - are often kept in for 24 hours.

The wards can become very busy in the mornings upon admittance of the D & E cases.

At night the unit is run as one with the Accident and Emergency unit as this makes for sensible and flexible deployment of staff.

A certain amount of demanding work can be placed on the staff owing to the complete variety of overnight admissions (including drug-overdose and psychiatric).

WORKLOAD AND STAFFING

The use of the beds is approximately split as follows:

Day-surgery	8	
A & E patients	10	(recovery/observation up to 48 hours)
Staff/relatives	2	(overnight accommodation)
Total	20	

The staffing figures (whole time equivalents) stand at:

Sister	1	
SRN	3	
SEN	1	(2 part-time)
Nursing auxiliaries	3	

ACCOMMODATION : ENVIRONMENT

Observation and supervision are felt to be poor, particulary from the nurses station and 'open' bays or bays with an upper half glass partition might have been better.

The size of the bays (4 beds) seems to be satisfactory.

The drugs cupboard is situated in Central Treatment Suite and is therefore somewhat inconveniently placed.

The staff do not like the openness of the supply room because it is particularly accessible to certain types of patient, such as the psychiatric and overdose patients who are likely to go looking for syringes etc.

The staff would like to have suction and oxygen points in all bed-bays, as there have not been sufficient points available in the past.

The staff have also been concerned that the window can be opened fully, and are asking to have blocks installed to restrict the opening width.

OUT-PATIENTS AND DAY-PATIENTS
DAY AND EMERGENCY UNIT

CONCLUSIONS

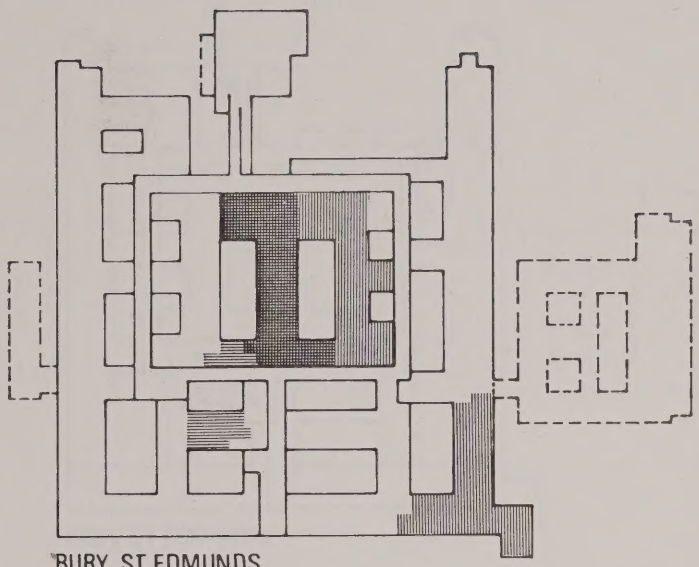
The Day and Emergency Unit at both hospitals seems to be run very much in accordance with the original policies, if anything with a very flexible attitude by all staff concerned.

The policies did not anticipate the need to keep patients in for 24 - 48 hours but both hospitals have found this necessary on occasions and have found no problem in making appropriate arrangements.

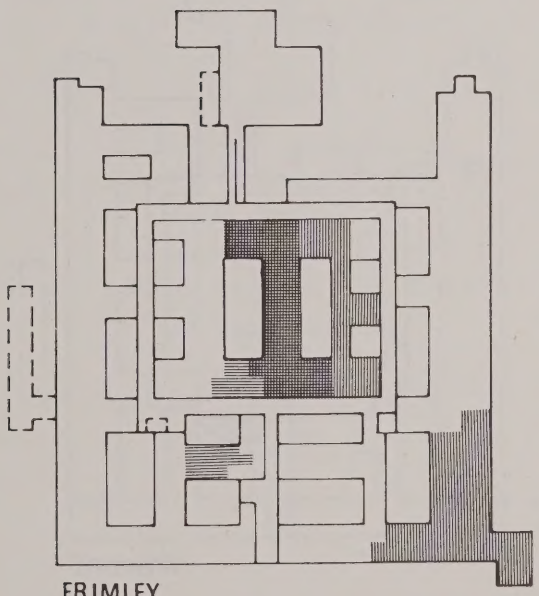
The policy of dispatching patients from the unit to wards before or while the wards day staff are coming on causes a certain amount of confusion and problems over bed-allocation. It is one aspect of organisation that could cause communications between the wards and the unit to become strained.

The need for slightly more open or visible ward/bed areas has been mentioned and is endorsed by the staff finding 'observation' difficult. The single rooms at the end of the unit present the biggest difficulty here, and at both hospitals they are used for overnight doctor/relative accommodation.

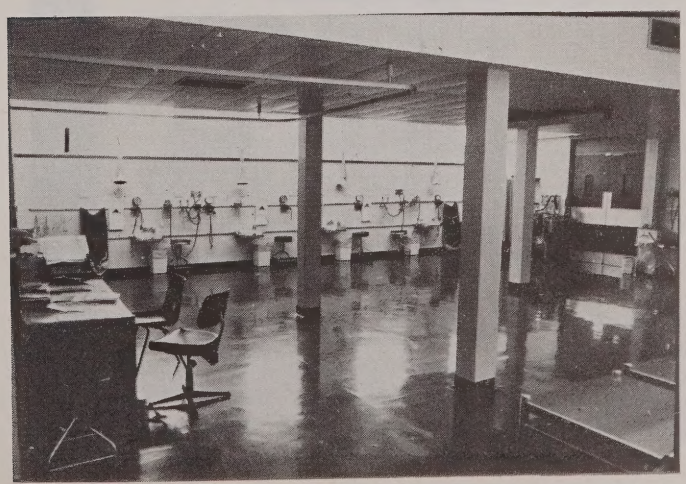
Treatment & Diagnostic Services.



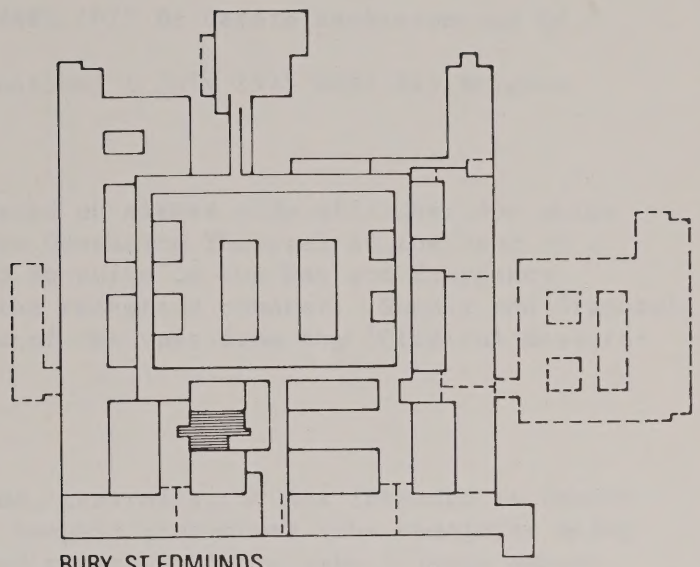
BURY ST EDMUNDS



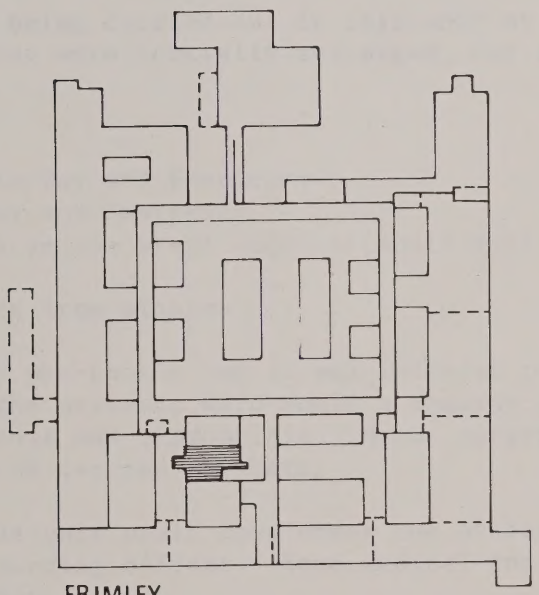
FRIMLEY



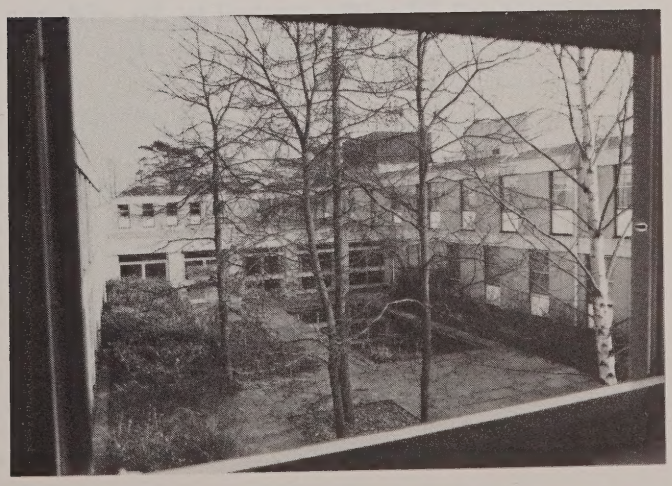
Central-Treatment-Suite.



BURY ST EDMUNDS



FRIMLEY



TREATMENT AND DIAGNOSTIC SERVICES : CENTRAL TREATMENT SUITE

Because this facility, its function, location and administration have been the subject of numerous studies and a film by the DHSS, the information contained will be very general, following the format and layout of this report.

Reference should be made to:

'Space Utilisation in Hospitals' DHSS/MARU 1977 Dr Carole Rawlinson and to

'Central Treatment Facilities - an Evaluation' 1 July 1975 DHSS Ray Brigden.

LOCATION AND DESCRIPTION

The Central Treatment Rooms (5) are located on either side of a corridor which runs parallel to the main street near the Operating Theatres at the head of the main staricase. The unit is planned en-suite to the Day and Emergency Unit and access would normally be past the reception counter. Supply and disposal access would take place at the other end of the unit from the 'Clinical Measurement' link corridor.

PURPOSE, FUNCTION AND ADMINISTRATION

In providing this bank of treatment rooms, centrally, it was intended to remove from the wards all treatments requiring aseptic procedures (the remainder being carried out at the patients bedsides) and consequently to save a large amount of duplicated departmental space. Minor treatments for children and specialised out-patient procedures would, however, be carried out in the appropriate department.

The flexibility and range of procedures being carried out in this unit at both hospitals would probably exceed those that were initially envisaged, but it was planned to take:

1 In-patients from adult acute wards
2 Day patients booked and admitted via Day and Emergency
3 Certain A & E cases admitted via Day and Emergency
4 Sick staff who cannot be dealt with in the Staff (Occupational) Health Centre
5 Certain out-patients referred direct from clinics

The use of these rooms would normally be pre-booked and it was intended that for in-patients a nurse allocated from the patients ward would accompany the patient to carry out the treatment, if this was appropriate. Minor surgery under a doctor or consultant might also be carried out here.

Nursing staffing would be minimal but the unit would come under the overall management of a sister and a (Grade 7) nursing officer. Some medical and nurse teaching would also take place in the unit.

It was envisaged that the rooms would be capable of allowing 100-120 treatments /day to take place.

PURPOSE, FUNCTION AND ADMINISTRATION

The proportion of numbers of dressings to number of treatments carried out in this suite was never determined in the Planning Policies, but perhaps because a number of dressings are carried out on the wards (as the policies suggest) and the rest are block-booked, it has enabled a wide range of surgical check-ups and procedures to be carried out in these rooms.

These procedures include excision of lumps, vasectomies, biopsies, cysts, fibroscopies, dental extractions and rheumatology procedures. ENT procedures are not carried out.

Out-patients are booked in and come via Day and Emergency beds. A small number of private patients are also treated when time and staff are available.

Initially there were problems in borrowing equipment and trays from TSSU. This has now been solved by CTS having their own supply with deliveries from CSSD. However, the storage area is proving too small for this system and circulation is tight when the trolleys for dressings or treatments are being laid up. These trolleys are actually taken into each room, so this makes the hatches redundant. Instead they are used for topping-up supplies and packs and are then locked from the inside.

There are some problems at the beginning of the week in the wards when surgeons (including the orthopaedic surgeons) prefer to do their rounds before seeing the patients in D & E or in the Central Treatment Suite. However, the surgeons generally believe that the provision of CTS was an excellent idea ... 'the right approach to surgical dressings' ... and that in replacing scattered treatment rooms (around the hospital) ... 'bacteriologically unsound' procedures have been greatly reduced.

The Central Treatment Suite is also used for nursing examinations and assessments. The idea is new, and in some wards seems to have affected the practice of team-nursing training. However, the problem is seen as one of getting used to the Central Treatment Suite and creating adaptable nursing teams (to provide for nurses going to CTS to carry out procedures)

WORKLOAD AND STAFFING

No detailed figures were available on staffing levels, but the Nursing Officer/sister is aided by a part-time staff nurse and a part-time nursing auxiliary. A pupil/student (SEN/SRN) should also be allocated but this only happens occasionally. Additionally nurses are available from a central 'pool' as and when necessary.

The suite has also a receptionist on duty during the day.

The workload is varied and more extensive than was perhaps envisaged in the policies.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

General comments about the design of the unit indicate a reasonable degree of satisfaction.

The ventilation has been modified as the solar gain used to be enormous (up to 100° F/38°C) and additional convector coolers have been added to the treatment rooms.

Ventilation in the disposal room is still poor.

TREATMENT AND DIAGNOSTIC SERVICES — FRIMLEY
CENTRAL TREATMENT SUITE

PURPOSE, FUNCTION AND ADMINISTRATION

In general, the Central Treatment Suite is used as was stated in the policies, except that patients are rarely sent from A & E and staff will only be treated if they happen to be in-patients (there is no connection with the Occupational Health Centre).

Two treatment rooms are used for minor surgery and endoscopy, the other three are used for dressings. Because of the type of treatments (such as endoscopies etc), it is felt that a preparation/supply room would have been better placed en-suite with each room, as the clean utility room is considered to be too far away.

The nursing officer for the suite is not in control of the D & E beds and feels that whilst it is possible to 'borrow' them, a separate recovery area might be useful.

There are some problems with the intake of patients needing dressings which involve the use of a bath (such as abdoperineal excision of rectum). These are not done in the wards and the disposal of smelly dressings should have been catered for by the provision of a unit incinerator. It would have been to some advantage to have another assisted bathroom with an 'ambulift'.

Endoscopies other than gastroscopies and colonoscopies are not carried out in this suite, but the unit does carry out lumbar punctures, chest aspirations and preparation for major surgery.

Instruments used for treatment are sterilised in TSSU.

WORKLOAD AND STAFFING

No detailed information was available on the workload but approximately 70 patients/day (Monday-Friday) and 35 patients/day (weekends) are treated.

In addition, approximately 500-600 endoscopies/year are carried out.

Staffing levels in wte stand at:

Sister	0.75	
SRN	4.75	
SEN	1.65	
Receptionist	1	(daytime only)
Domestic	1.5	

The Nursing Officer in charge of CTS is also responsible for OPD.

A typical weekly breakdown is given below:

Minor Surgery	Speciality	Number
Lumps & Biopsies Vasectomies Fibroscopies Cystoscopies Urethral Dilations	Surgery	29
Extractions etc Removal of sutures	Dental	7
Cysts Weiss operations Entropians Ectropians	Opthalmology	12
Injections Aspirations (Shoulders, Knees. elbows etc)	Rheumatology	6
	TOTAL	54
Orthopaedic dressings etc	Orthopaedics	24
Other Dressings Treatments Investigations	General	+/- 200
	TYPICAL WEEKLY TOTAL	278

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

Few comments about any problems were made. The supplies room is felt to be too small for the requirements of the numbers and types of treatments being carried out.

Ventilation in the disposal room is poor, and heating generally is too variable.

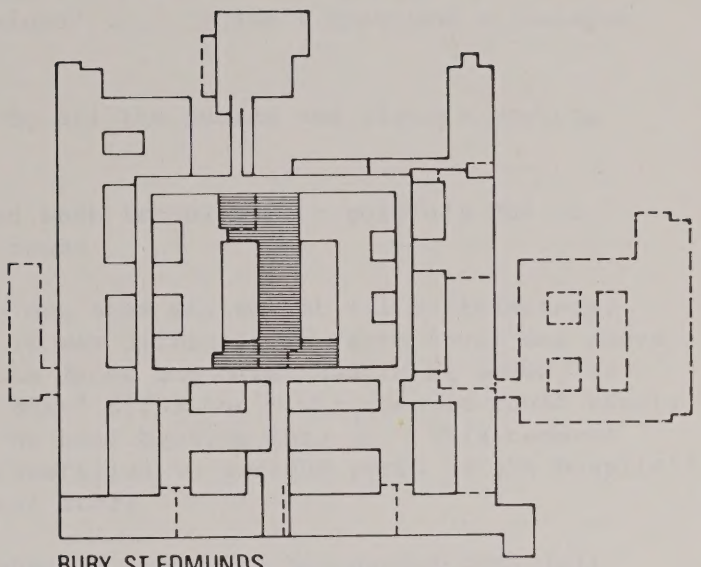
Clerestorey windows are causing problems with glare, and there is felt to be too high a level of artificial lighting which with the light reflective decoration also causes glare.

TREATMENT AND DIAGNOSTIC SERVICES
CENTRAL TREATMENT SUITE

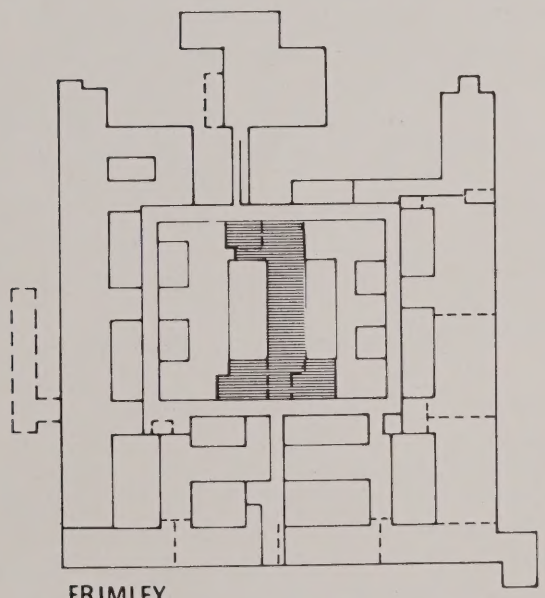
CONCLUSIONS

The central Treatment Rooms in both hospitals appear to have been a useful and successful innovation, enabling, if anything, a wider range of treatments and procedures to be carried out than was envisaged in the policies.

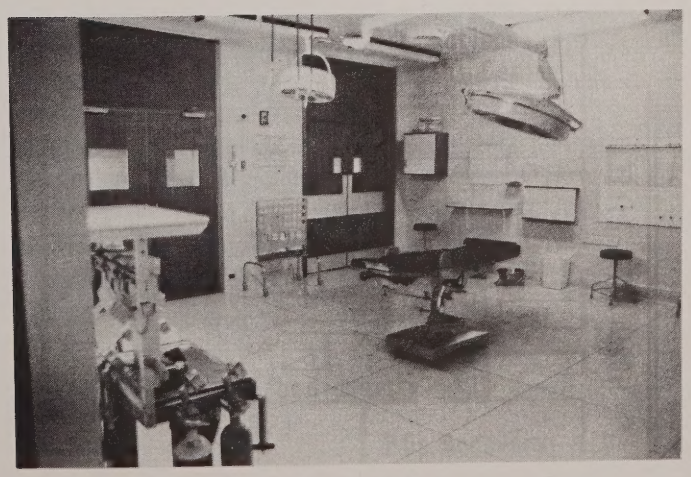
Operating Theatres, Recovery & T.S.S.U.



BURY ST EDMUNDS



FRIMLEY



Attention should be given to ensuring that a satisfactory relationship is encouraged between the staff using the Suite and those organising the adjacent Day and Emergency beds, as the successful operation of the Suite and the continuity of good patient care depend on this.

The surgeons at Bury St Edmunds were particularly complimentary about the provision of the Central Treatment Rooms ... 'they have good surroundings, good equipment, expert staff to carry out the work and the continuity of communication with ward staff is maintained' ... 'I don't know how we managed without it (Central Treatment Suite)'.

Two points of detail were commented on by all the nurses and sisters working in the CTS:

1 The ventilation/heating problem had been troublesome - possibly due to solar gain and orientation of the rooms.

2 The minor operations light on its long stem was not at all satisfactory, as it slipped after being set, as it was difficult to reach (over and above the patient), as it was difficult to focus and often had to be moved, as it was dangerous in a crowded or 'busy' situation - when people could easily give themselves a nasty crack on the head backing into it. This comment about this type of light fitting (installed in various parts of the hospital) was endorsed by many of the hospital staff.

The medical staff at both hospitals wished to emphasise how useful they felt the Central Treatment Suite to be. It was 'the most important innovation' of the principles generated by Best Buy planning.

TREATMENT AND DIAGNOSTIC SERVICES
OPERATING THEATRES, RECOVERY ROOM, THEATRE STERILE SUPPLIES UNIT (TSSU)

LOCATION AND DESCRIPTION

This group of facilities is located centrally on the first floor with controlled access at both ends from the surrounding main hospital street. The main entrance to the suite faces the patient lifts with staff-changing rooms to one side, and the trolley exchange and post-operative recovery room leading to ITU, on the other. A reception hatch overlooks and controls staff and patient admission and bed/trolley exchange and cleaning. There are 6 operating theatres, each with its anaesthetic, supplies and scrub-up rooms, and a shared exit/disposal space between pairs. TSSU is situated at the rear end of the single corridor suite and is sited adjacent to a short internal link corridor connecting to the Central Delivery Suite and SCBU.

PURPOSE, FUNCTION AND ADMINISTRATION

This is an area where special detailed procedures govern all activities, a guide to which may be referred to in the Planning Policies and in detail in the individual hospital's Operational Policies. Further information on maintenance, supply and disposal should be available from the special studies being carried out for the DHSS by MARU (Hazel Grayson) and others. The information contained here is very general.

Facilities were to be available for the following surgical procedures:

1 ENT surgery

2 Dental surgery

3 General surgery

4 Gynaecological surgery

5 Obstetric surgery

6 Ophthalmic surgery

7 Orthopaedic surgery

8 Trauma and Emergency surgery

The usual procedure of compiling theatre lists for in-patient surgery will apply; emergency obstetric cases will be received direct from that department, accident and emergency patients will travel via the lift direct to theatres if necessary, and otherwise will join the day patients in Day and Emergency for preparation prior to going to theatres. It is intended that a majority of equipment including operating tables and disposal trolleys will be mobile and that no equipment (other than the specially cleaned patients beds) will enter or leave the department except for special processing, replacement and return.

The single corridor 'system' seems to be a satisfactory planning decision and it was intended that all waste and disposable items should be bagged and sealed in the theatres towards the end of an operation for disposal and/or processing by TSSU staff.

The operating department will be under the control of a Grade 7 nursing officer, supported by a Grade 6 theatre sister and it was intended that full or part time nursing staff should be specially trained and should perhaps work on a shift or rota system.

'Clean' areas and 'dirty' entrance areas to the suite are delineated by change in floor colouring; precise gowning and shoe-changing procedures permit people to transfer from one area to another.

Where X-Ray and image intensifier equipment is required, the X-Ray staff will operate this and it was intended to provide appropriate socket outlets and film processing facilities within the operating suite.

TSSU, which will requisition and process theatre instruments and will act as a storage area for CSSD packs, is intended to be run as an independent department and only the TSSU supervisor will have access (via changing-gowning/footwear procedure) to the operating theatre suite.

The Recovery Room was intended to be run under the direction of the ITU sister and nursing officer. Whilst it would be provided with suitable gas and suction outlets, it would not be part of the 'clean' zone of the operating department and as such recovery room staff were not intended to enter the 'clean' zone.

TREATMENT AMD DIAGNOSTIC SERVICES — BURY ST EDMUNDS
OPERATING THEATRES, RECOVERY ROOM AND TSSU

PURPOSE, FUNCTION AND ADMINISTRATION

The TSSU and Recovery Room are considered to be 'an integral part of the Operating Theatre Suite' and all come under the control of a Nursing Officer. However, staff and patient movement through the Suite is controlled by procedures delineating 'clean' from 'dirty' zones. The Recovery Room and the sterile store of TSSU are contained in the 'clean' zone. ITU is not within this zone coming under a separate nursing officer, although patient transfer from recovery can occur as and when necessary. (This policy differs from the Planning Policies).

A consultant anaesthetist/surgeon and the Recovery ward sister maintain responsibility for post-operative patients until they are fit for discharge under the ward nurses care.

Although the procedure of allocating pairs of theatres can be arranged it does not normally occur as the number of theatres is too small.

The single corridor appears to be satisfactory although some staff feel it makes more work for them in having to wrap and bag waste.

Surgeons usually enter the Theatre via the Anaesthetic Room, and then the scrub-up area so that they can examine or check the patient before induction. Requests for the next patient are made by a joint decision between the sister, the surgeon and the anaesthetist. However, patients are not 'held' in the reception area because it is not considered good nursing practice. The patient is anaesthetised on the trolley and is then transferred to the operating table in the Theatre. However, the design of the Theatres and the spacious corridor is permitting alternative procedures to take place and more patients are being brought into the Theatres on their beds (after suitable bed-cleaning procedures), and the operating tables are occasionally moved for direct transfer as well.

Special 'freezer packs' of blood are now issued by the blood bank as required for each session so no blood refrigerator is needed. Specimens are usually retained until the end of each session - with the exception of those for frozen section - and sent in batches to Pathology.

Generally the facilities for patient treatment and care are considered as excellent and the record for control of infection has been very good.

The TSSU system of sterilising and providing pre-set trays (rather than having them sterilised within the Theatres) is considered good, but the shortage of instruments is a continual problem. The TSSU staff are encouraged to gown and come and watch operations to give them a better understanding of what they are doing.

There seem to be no problems with the policies of use of Recovery Room.

WORKLOAD AND STAFFING

In general the move to the new hospital was much appreciated and the workload throughput was greatly increased from 4000 to 6000 patients in the first year owing to the 'better facilities'.

37 elective sessions/week are held. Some emergencies are added to these sessions, the remainder are done in the allocated emergency theatre.

Staffing levels are considered adequate except at night when inexperienced staff can cause delays in looking for the right equipment.

The present staffing figures include:

Operating		TSSU	Recovery
Nursing Officer	1		
Sisters	5		1
Staff Nurses	5½	1	5
SEN	4		2
Nursing Auxillary			1
OD Assistants (qualified)	5		
(trainees)	2-6		
Receptionist/Typist	1		
Clerk	½		
Operatives		3 (+ 3p/tpm)	
Autoclave Attendent		1	
Consultant			5
Senior Registor			1
Registrar			1+1 p/t
SHO			2

ACCOMMODATION

The accommodation in general seems to be very much appreciated, but several important comments need to be included:

1 A larger theatre is needed for hip-surgery and arterial work.

2 Although the lighting, electrical services and medical gases are satisfactory in the Theatres, the terrazzo floors are becoming uneven because of the movement of the operating tables, and the temperature and humidity control is not good.

3 The Theatre Supply rooms are narrow and cramped and don't always provide sufficient space for containing all the trolleys and trays needed for a session.

4 Similarly, TSSU storage and circulation is cramped.

5 The single corridor is well liked and is very light and airy - a refreshing change from the Theatre environment

6 Anaesthetic rooms appear adequate in size but the gas pendants should have been positioned off-centre.

7 The surgeon's rest room is adequate but no office or room was provided for the anaesthetists - which would enable them to work while remaining near the Recovery room. One rest room has been adopted for Nursing Officer's use for interviews and other work. The two remaining rest rooms are allocated one to medical and one to all other theatre staff and they appear to work very well.

8 The changing-rooms are 'disastrous', 'like a slum', being completely inadequate in spaces and fittings and having a very poor layout.

ENVIRONMENT AND ENGINEERING

Ventilation in the Theatres has recently been improved with a special scavenging system for gases being installed from the roof; however, particularly at the beginning of the day the rate of ventilation fluctuates widely. In the Recovery room ventilation again is rather poor and the area becomes very hot in summer with large amounts of solar glare coming through clerestory windows.

Some people would have preferred that nitrous oxide supply would be safer in cylinders and it was commented that a swing-boom for the medical gases would be more flexible than the two fixed pendant points.

One or two other small points include:

1 the desirability for a direct telephone line out.

2 the provision of a bigger lotion warming cabinet.

3 the provision of a larger room for mops and buckets outside the disposal/ exit bays.

Planned preventive maintenance seems to work well, although the staff gain access to the department through the normal changing room procedure rather than use the bulkheads.

TREATMENT AND DIAGNOSTIC SERVICES FRIMLEY
OPERATING THEATRES RECOVERY ROOM
THEATRE STERILE SUPPLIES DEPT (TSSU)

PURPOSE, FUNCTION AND ADMINISTRATION

The Theatres, Recovery, TSSU and ITU all come under the administrative organisation of one Nursing Officer although ITU is separately run by its own sister, and does not appear to be contained in the designated 'clean zone' which extends into the Recovery Room.

All the surgical procedures listed in the policies are carried out and in addition, the following are also done:

faciomaxillary surgery
gu surgery
vascular surgery

Hip-replacements are also carried out and Theatre 6 has been adapted to take a 'Charnley Howarth enclosure'.

The Theatres are used occasionally at night, but a number of accidents and emergency cases are taken to military hospitals in the locality.

Theatre 1 is allocated generally as the emergency theatre and is stocked to cope with emergency caesarian sections.

Theatre 5 is additionally stocked to specialise in Eyes, ENT and Dental cases.

Theatre 6 is allocated and stocked for orthopaedic work. Each of the Theatres is adequately stocked to cope with a complete list, although shortages occur on the day which includes 4 gynaecological lists.

Generally patients are anaesthetised on the trolley and are transferred onto the operating table in the Theatre - this occurs because it is difficult to move the mobile tables over the uneven floors.

The TSSU staff are encouraged to spend some time in the Theatres in order to understand the packing requirements, and they are responsible for stocking the supply rooms. Unused instruments are left on the trays to reduce work in the TSSU and disposable plastic aprons are also used to reduce TSSU work.

The TSSU only serves the Operating Department - Central Treatment, Delivery Suite, A & E and OPD get their supplies from CSSD.

The TSSU system originally met with some resistance, but it is now generally accepted and well-liked.

Control of infection has not been adversely affected by the provision of a single corridor Operating Suite.

There is a 24 hour service for housekeeping and in addition contract cleaners come in once a month to clean the Theatre walls and ceilings.

As at Bury St Edmunds, blood required for sessions is sent up in freezer-packs as necessary. A blood fridge is therefore not required. However, the central drugs fridge is useful, and each Theatre has its own pharmacy box.

WORKLOAD AND STAFFING

Although no detailed information was available, 40 elective sessions/week are carried out, and in addition any emergencies.

Staffing levels including TSSU and Recovery stand at:

Charge Nurses/Sisters	11.5
Staff Nurses (SRN)	9
SEN	5.5
Nursing Auxillaries	4
Operating Dept Assistants	16
Equipment Technician	1
TSSU Packers	11

Autoclave Attendant		1.5
Inside Porters		4
Outside Porters (from General pool)		
Receptionist		1
Housekeeping Staff	(approx)	11
Clinical Teacher		0.5

(These figures include Night Staff)

TOTAL 76 wte

ACCOMMODATION

In general the size of Theatres and the single corridor has been satisfactory to all staff, the standardised theatre facilitates working routine but the 'handing' of the ancillary spaces initially proved confusing.

The Theatres have been renumbered to start at Number 1 near the main entrance.

Other comments on accommodation concern the following points:

1 The anaesthetic rooms are sufficient in size but the central gases pendant is awkward.

2 The scrub-up/gowing area is tighly planned for 3 people scrubbing at one time. Only 2 can gown at a time. The dispenser fixtures are not very satisfactory.

3 Although the supplies rooms hold enough packs for a session, they are felt to be too small.

4 The cleaners cupboard in the exit/disposal bay is very inadequate in size and the design of the slop-hopper makes it messy to use.

5 Rest rooms are adequate and are used as intended.

6 Staff changing rooms 'are a disaster'. They are too small, badly arranged and no access to the WC's is provided from the 'clean' side.

7 The receptionists office is considered claustrophobic and seems to have caused a high 'sickness' rate and high staffing turnover.

8 The porters base is considered too small as they often have four on duty at a time.

9 The equipment/cleaning/store room is too small and no bench has been provided for paper work. The seminar room is also used as a store room.

10 The X-Ray processing room had no black-out facilities and is now crammed with equipment.

11 The reception area is used as the bed wash area, and not for 'holding' patients.

12 The TSSU is considered much too small, having a cramped working area and insufficient storage space. Ventilation has proved a problem in this area.

ENVIRONMENT AND ENGINEERING

Ventilation has been a general problem and for small offices and the reception area is not very satisfactory.

The gases-retrieval system installed by Howarth Engineering is not entirely without faults and is very noisy.

No compressed air was installed in the suite and the manifold has had to be placed outside one of the theatres.

The electricity emergency supply switch has given trouble in automatic switch-over.

For maintenance, every theatre is closed once every 3 weeks for a thorough check and additionally the ducting is checked once every 6 weeks. This system appears to be very satisfactory.

TREATMENT AND DIAGNOSTIC SERVICES : OPERATING THEATRES, RECOVERY & TSSU

CONCLUSIONS

The Operating Theatre Suite appears to be well appointed, and well placed, although its relationship to further departments, such as Children's, ENT and Ophthalmic wards necessitates rather long pre and post operative journeys.

It is not thought a good idea, in general, to have such a direct 'back-route' into theatres from Central Delivery Suite, because it enables people to bypass the usual changing disciplines. At Bury this entrance is used only for failed forceps deliveries, the kind of emergency envisaged by the policies. A shared transfer zone would have been appreciated.

The size of theatres at Bury seems to be reasonably adequate for the type of procedures being undertaken; the introduction of a 'Charnley Enclosure' at Frimley left very little space to spare in one theatre.

Staff generally like working in the Theatre Suite despite the problems in detailed design, but the changing room arrangements and design have proved very poor and that whole area should have been completely re-thought at planning stage.

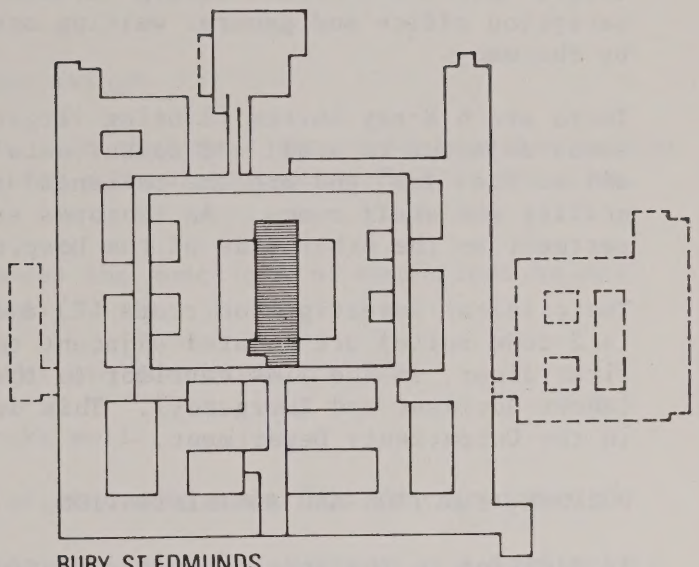
The organisation of 'clean' and 'dirty' areas has been altered from the policies, in both hospitals; but given a little confusion occuring for new staff, the system appears to be satisfactory and the close relationship of and access to the ITU is felt to be very useful.

Although flexible use is permitted by having a suite of identical theatres it is still fairly common to find a certain amount of allocation according to type

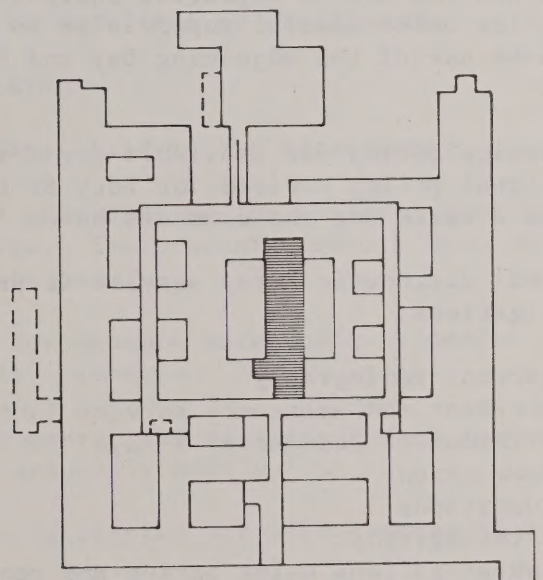
of operation. The ophthalmic surgeons, in particular, would prefer this - they are worried about control of infection and they would also prefer to have the permanent allocation of one theatre so that large, delicate equipment could be fixed, thus avoiding damage from being moved around.

The detailed planning of various rooms and spaces needs to be reviewed, particularly with regard to ventilation and the installation of medical gas supplies, but in general the suite is pleasant to work in and the single supply/disposal/communications corridor policy appears to be a success.

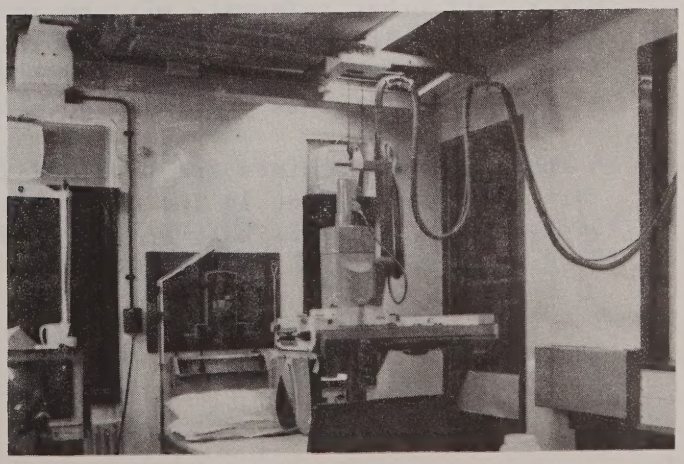
X-ray Department.



BURY ST EDMUNDS



FRIMLEY



LOCATION AND DESCRIPTION

The X-ray department is located in the middle of the central 'core' on the ground floor, with its entrance facing the bed lifts, flanked internally by the filing/reception office and general waiting area and 'externally' by the Chapel and by Pharmacy.

There are 6 X-ray suites (2 being larger than the others), patients' changing areas adjacent to staff and consultants' offices and the records/film store, and at the 'far' end are the patients' recovery cubicles surrounded by ancillary utility and staff rooms. An isotopes store is placed at the rear of this department on the other side of the hospital street.

The clinical investigation rooms (2) and what originally was termed 'thermography' (a 2 room suite) are located adjacent to the Central Treatment Suite on the first floor, in the link corridor to the wards at the front of the hospital (above Accident and Emergency). This department also includes a clinical room in the Outpatients Department.

PURPOSE, FUNCTION AND ADMINISTRATION

In addition to the investigations carried out by the Pathology and X-ray (radiolog departments, there was a need for Clinical Investigation facilities for electrocardiography, pulmonary function tests and other procedures requiring specialised skills and the use of expensive equipment. It was decided to centralise these facilities under special supervision so that GP and outpatient referrals could also make use of the adjoining Day and Emergency beds and the Central Treatment Rooms.

No planning policy was available for X-ray services and organisation, but the operational policy devised for Bury St Edmunds was drafted in 1972 and has been used as a basis for the comments here.

An 'area' diagnostic X-ray service is provided, which includes the following investigations:

- general radiography
- accident and emergency service (including rta's)
- orthodontic and dental X-rays
- mammography
- tomography
- arteriography
- investigations using barium and opaque media

In-patients and 'special investigations' will be organised on an appointment basis, all other referrals will be in 'open sessions'. Patients requiring gowning will change in the changing cubicles and will await being escorted to the X-ray room by the radiographer (who is notified by a numbered request form system). In-patients requiring gowning will be changed in their wards.

4 mobile X-ray machines are provided for general hospital use, one on each floor for use anywhere, one in the Operating Theatre Suite and one in Accident and Emergency. They will only be operated and moved under X-ray staff supervision.

PURPOSE, FUNCTION AND ADMINISTRATION

The department appears to function well in accordance with its operational policies and it is well sited and sufficiently accommodates all the functions necessary. The Accident and Emergency staff would have preferred a more direct access to the main department.

General comments were made about the following:

1 Staff changing facilities - it was felt that more should be provided within the department itself, but the policy did not recognise this at the time of planning.

2 The internal telephone system impedes the functions of communication and GPO lines would have been preferred.

3 Sound and confidentiality in general are poorly controlled.

4 The immediate reporting system works well.

5 Multiple dark rooms are appreciated, but need more film pin-up space.

6 Patients' changing areas are appreciated as being integral - a good policy.

7 The general layout is good.

No comments or figures were available on work load or staffing.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

A number of comments were made during the visit to the department:

1 More X-ray rooms should have been provided and the existing ones could have been planned to be more square. The present number 2 room is very 'corridor-like' and this limits its use.

2 Space is tight in certain areas; for example more space is needed in the film-filing area ('the shortage is chronic').

3 The X-ray rooms could have been higher. The ceiling mounted tubes tend to be obstructed and moving them around is difficult.

4 There is a lack of secure storage facilities for silver-extraction.

5 The department staff would prefer to have maintenance workshops within the department.

6 The ventilation is regarded as being sub-standard; a lot of heat emanates from the equipment and some areas become too hot to work in, particularly internal rooms.

OTHER

One other point of importance was the inadequacy in type and design of the drains. Considerable amounts of chemical waste emanated from the department and drains frequently became blocked.

PURPOSE, FUNCTION AND ADMINISTRATION

Generally the department works well and provides for the services described earlier.

Changes are taking place in the purpose and function of the unit. Some of these could not necessarily have been foreseen at the time of planning.

The location of the department is good, but a more direct link to Accident and Emergency would have been useful. The provisions of the department appear to satisfy most staff.

WORKLOAD AND STAFFING

The main comments concerned the greatly increased workload which was never allowed for in the original planning policies and is putting pressure as much on this department as elsewhere. This is beginning to affect the numbers of staff required and if the trend continues (ie the local population increases) then accommodation will become tight.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

Many of the comments echo those made at Bury St Edmunds. In particular the following points were made:

1 Storage space was lacking and would not cope with an expanding workload.

2 Most of the offices were satisfactory, but two were used as through-routes which was not acceptable.

3 The X-ray rooms are found to be rather small to accommodate the Kings Fund beds and still leave enough circualation space and room to position equipment.

OTHER

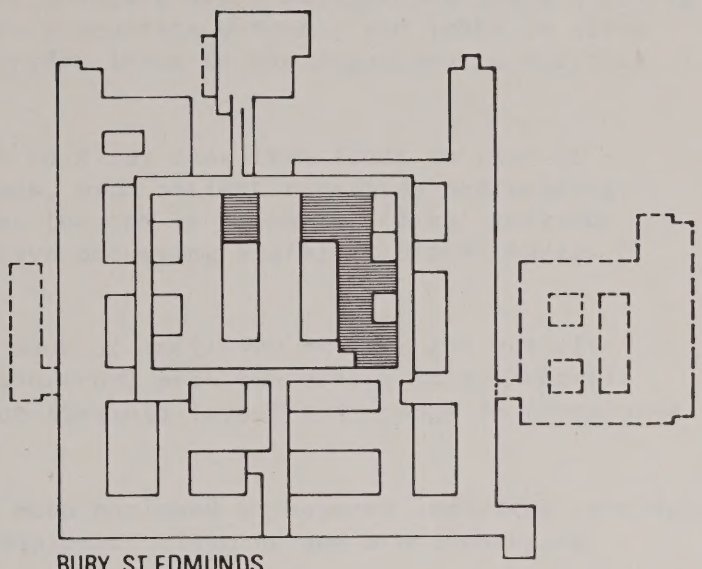
As at Bury St Edmunds, the engineers, maintenance and works staff mentioned the problems of the drains, which are poorly sited for access and have not been designed to adequately cope with chemical waste.

TREATMENT AND DIAGNOSTIC SERVICES CONCLUSIONS
X-RAY DEPARTMENT AND CLINICAL INVESTIGATION

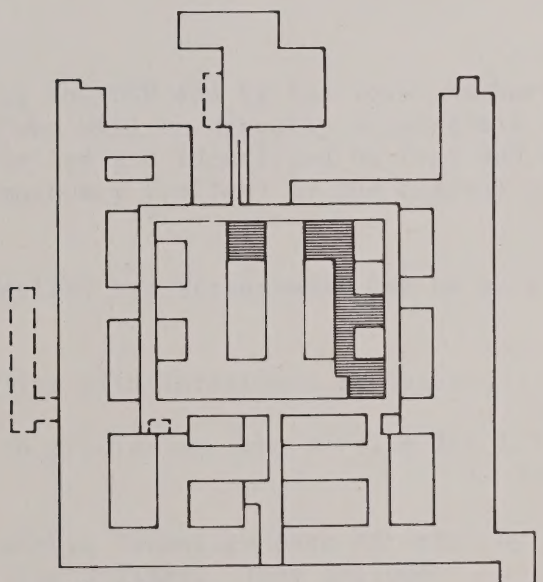
In the planning policies very little was written about the combined and separate functions of these departments. The X-ray facilities provide for the usual diagnostic and investigation procedures and radio-active and radio-opaque materials are used for investigation only. Patients requiring radiological treatment of more sophisticated type are sent to larger specialist hospitals in Cambridge, London and elsewhere.

Whilst the departments appear to be functioning reasonably well, both are somewhat short of storage space and the dark room facilities are constricted, confined and lacking in proper layout facilities. It is doubtful whether the department at Frimley could accommodate a much bigger increase in workload as the waiting area is often full and queuing of beds in the corridor also occurs. However, the department is not under excessive pressure and the management of it has coped with the unprecedented effects of increased catchment population demands.

Pathology Dept. & Mortuary.



BURY ST EDMUNDS



FRIMLEY

LOCATION AND DESCRIPTION

The Mortuary is located at the rear of the central block of the hospital, between the end of the X-ray department and plant room and the nurse education block. The 3-table post-mortem area looks out onto a courtyard, and a corridor between the 27-place refrigerated body-store and changing and viewing rooms leads directly to the rear of the hospital street where a separate entrance and lobby is sited beneath the 2-way ramp. A separate corridor leads to the department's visitors and viewing room.

The Pathology department sited parallel to X-ray runs from front to rear of the hospital street, in the central block, with patient reception and waiting, specimen rooms and blood bank facilities located in a central 'link' corridor and 6 general and technicians working-bays occupying a similar block nearer the front of the hospital.

The central axial corridor divides the bank of ancillary offices and specific procedures rooms from an open 11-bay laboratory area containing interchangable bench units fitted to a fixed spine (for flexible layout and change in procedures and organisation policies).

At the rear end of the department, are more enclosed workspaces including cytology, histology, photomicrography rooms and equipment cleaning and staff changing facilities.

No animal house is provided.

PURPOSE, FUNCTION AND ADMINISTRATION

The mortuary is designed for use both by the DGH and by the local authority. It is staffed by a mortuary technician who will be directly responsible to the Consultant Pathologist. Bodies are labelled and identified by tags and where necessary are transported (usually by mortuary trolley) by the central portering staff pool.

Embalming is not carried out in the hospital but arrangement can be made for coroners examinations and inquests.

Special arrangements are made when dealing with infectious diseases.

The Pathology department was designed to provide an area service for 175,000 catchment population.

There were 4 divisions or departments within Pathology each directed by a Consultant Patholgist or senior Scientific Officer. They include:

Morbid anatomy	- histo-pathology cytology
Haematology	- clinical haematology blood transfusion
Chemical Pathology	- clinical biochemistry radio-isotopes

Microbiology - routine immunology (without the PHLS element)

General practitioners and local health centres could send specimens or refer patients direct, and the laboratories would fulfil a community function; however, it was envisaged that a sub-regional laboratory would carry out the more special procedures and tests.

All reception of samples and patients would take place in the reception area and facilities for specimen collecting of various categories are sited adjacent for those attending patients.

Special clinical procedures by the pathologists would be carried out in the Central Treatment Suite and those patients requiring tests using radio-isotopes will attend the clinical investigation facilities also on the first floor.

No figures for staffing numbers were included in the planning policies.

TREATMENT AND DIAGNOSTIC SERVICES BURY ST EDMUNDS
PATHOLOGY AND MOTUARY

PURPOSE, FUNCTION AND ADMINISTRATION

The department appears to be well sited and sufficiently spacious for the function described in the policies to be carried out. The location is good and is probably the most convenient for portering, speciment collection and patient clinics.

Links and liaison with community services are excellent and nearly half the requests for tests come from GP's and health centres.

The standard of patient care exercised by the department is good, although it is thought that it could be improved generally in the hospital (if it were possible to have a 'single captain of the hospital ship').

Policies are gradually changing under the influence of the NHS re-organisation, the Health and Safety at Work Act and the Fire Precautions Act. These could perhaps ultimately affect the expansion of the department: there would be problems in expanding clinical chemistry which is currently being maintained on a small scale.

Design changes are also being suggested in order to comply with the Acts and with current practice (see Accommodation).

One change of policy is in the requisitioning system for blood for the theatre sessions (refer to section on Operating Theatres).

Housekeeping :

This was generally good, but there seemed to be a high incidence of misplaced reports since the housekeepers became responsible for placing them in the case notes.

Design :

The hospital was generally appreciated by most of the pathology staff; the main problems were caused by the fact that 'the powers that be are reluctant to admit that there are deficiencies/shortcomings - these should have been expected - and they are so concerned to pour oil on troubled waters that

understandable remedial action has been ignored'.

WORKLOAD AND STAFFING

Approximately 50% of requests for tests come from outside the hospital, but the department caters for this demand with no problem.

The original staffing estimates were about right but recently there has been a slight increase in staff due to the workload increasing.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

Numerous comments were made about detail design problems - these were compiled in a report to the commissioning officer in 1974.

In general, the accommodation is sufficient but the following points still need attention:

Mortuary

1 The electric body-lifting trolley is slow and dangerous to operate, a hydraulic lift would have been better.

2 There have been problems with the refrigeration plant and an accurate visual temperature guage is needed.

3 There are problems of screening or locking the working areas so that embarrassment and lack of security may be avoided.

4 Storage and note-writing facilities are poor and the policy of dictating notes is not always practical.

Pathology

1 Planned preventive maintenance of equipment is done by contract and is considered reasonable - the main criticisms being directed to design faults that have not been rectified.

2 Ventilation is poor in many workplaces and after 4 years of complaining, the Pathologist had to call in the Health and Safety inspectorate in order to get it modified.

3 Ventilation in the histology cut-up room was dangerous. There was originally only one vent which drew possibly dangerous micro-organisms past the technicians face and discharged to atmosphere outside the dining room windows. This has now been modified and a glass safety screen has been installed.

4 The area allocated for female staff changing was insufficient - there are 20 female staff using an area suitable for only 3 or 4.

5 The reception counter is too low and staff and patients have complained. This has not been altered and the Pathology staff are now considering doing a modification themselves.

6 The inner rooms are generally hot and uncomfortable both physically and psychologically.

7 The worktops consisted of veneered plywood which had to be covered by non-absorbent paper because of wear and because of the possibilities of infection spreading.

PURPOSE, FUNCTION AND ADMINISTRATION

The department follows the functions laid out in the policies and is considered well placed and sufficiently large. If increases in requests for clinical chemistry continue, however, there will be considerable problems in storage particularly of the equipment necessary.

The effects of reorganisation have been thought to be responsible for certain problems of internal communication and decision-making in the hospital - part of the problem seems to be in the lack of authority to act upon decisions.

No particular comments were made about workload or staffing.

ACCOMMODATION, ENVIRONMENT AND ENGINEERING

Generally comments were favourable but again the department suffered from detail faults, as at Bury St Edmunds:

1 Ventilation was not found to be adequate and some areas were potentially dangerous. Particularly there are problems in the histology cut-up areas which suffer from odours. The formalin areas also suffer for the same reasons. More external ventilation is needed.

2 The mortuary windows are not sufficiently opaque and the surrounding areas at ground and first floor levels should be shielded a little more, visually.

3 Some of the minor rooms, particularly the internal rooms suffer from lack of natural air-movement and ventilation.

4 Staff changing areas in the department are considered inadequate - though not acutely so.

5 A gallery in the post-mortem room would have been very useful. This was not envisaged in the Planning Policies.

TREATMENT AND DIAGNOSTIC SERVICES : PATHOLOGY AND MORTUARY
CONCLUSIONS

In general the Pathology and Mortuary departments are well sited, have good access and communications and are sufficently spacious.

Faults have occured at the level of detail design and engineering and the department layout and functions are now coming under scrutiny owing to the provisions of reorganisation in the National Health Service and to legislation such as the 'Health and Safety at Work Act : 1974'.

In detail ventilation throughout the department has been poorly designed and is even dangerous. More local ventilation should be encouraged in order to prevent the corners and inner areas becoming confined and unpleasant to work in. The mechanical ventilation and routing of extract ducts has necessitated radical modification (it may or may not have been responsible for a high-rate or cross-infection and staff sickness in this and the Catering department above). This is an area of design that requires close re-examination.

The laboratory benches were not finished satisfactorily and the present arrangements for covering the tops is necessary to prevent the wood from wearing, and from propagating infection.

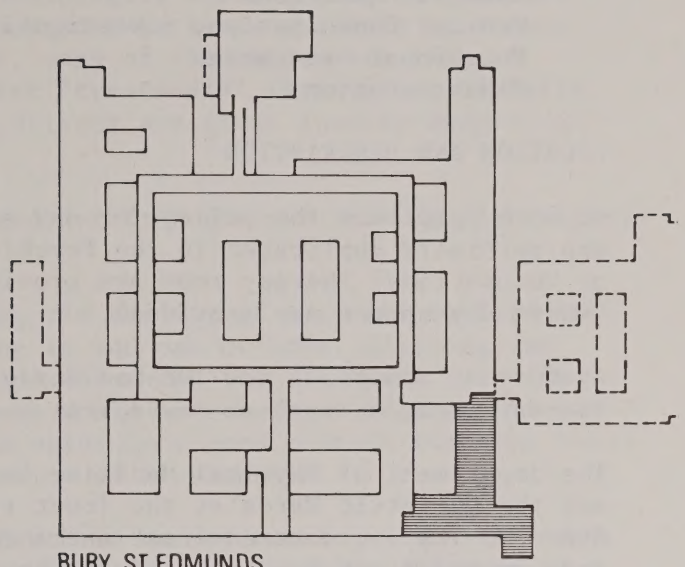
Drainage/Infection :

One very important problem with the drainage system was pointed out by the engineers. The waste from the pathology department runs directly into the same system that serves the Catering department. There are no grease traps in this system and blockages have occured which have caused local and potentially dangerous flooding in the pathology department.

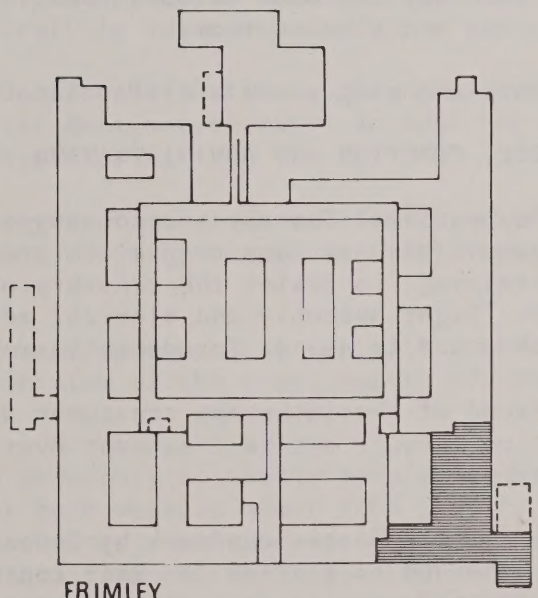
At Frimley chemical reactions have been taking place between the waste, the pipes and possibly the soil, resulting in a build up of gases and extremely difficult working conditions for the maintenance teams.

None of these problems are aided by the fact that the drains run under the building and the manholes are situated in the main hospital corridors and within departments. Access can thus be difficult, potentially dangerous and environmentally unpleasant.

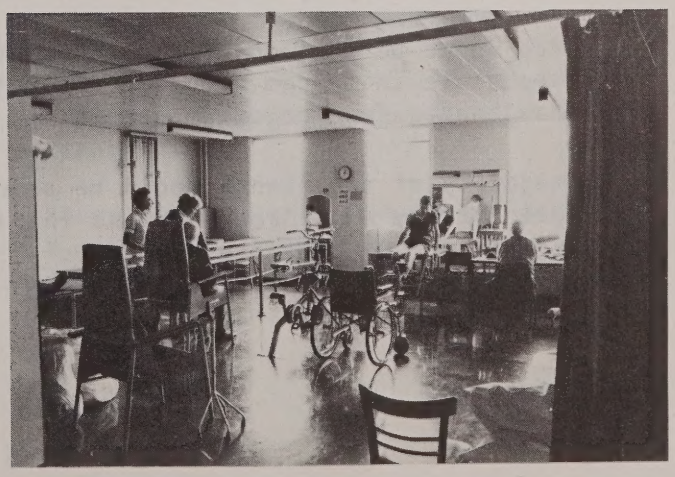
Department of Physical Medicine.



BURY ST EDMUNDS



FRIMLEY



TREATMENT AND DIAGNOSTIC SERVICES : DEPARTMENT OF PHYSICAL MEDICINE

This section includes:

- Occupational Therapy (OT)
- Physiotherapy (PT)
- Remedial Exercises
- Medical Consultation, investigation and treatment
- Functional Assessment
- Rehabilitation

LOCATION AND DESCRIPTION

At both hospitals the policy for day hospital provision meant that the facilities are partially duplicated in the Psychiatry department (where day-spaces and an Occupational Therapy room are provided) and in the adjacent Geriatric department (where day-spaces are provided).

At Bury St Edmunds a new 108-bed Geriatric block contains a separate Occupational Therapy area, as well as day-spaces.

The department of Physical Medicine is situated between the Outpatients department and the Geriatric Wards at the front right hand end of the hospital. The department has its own covered front entrance and there is a gym and an external exercise area on the right hand side of the hospital with space allocated for a hydrotherapy pool. In addition to the usual offices, Occupational Therapy consists of 2 workshop/training areas and a daily-living-activities kitchen/bedroom suite. Physiotherapy contains an open exercise area en-suite with treatment cubicles and a wax and plaster room.

Patients changing rooms are also incorporated.

PURPOSE, FUNCTION AND ADMINISTRATION

The Occupational Therapy section supposedly allows for the treatment of up to 100 people/day and aims to provide productive work, recreational activities and training 'to assist the recovery of function' in the heavy workshop, to permit 'light assembly and clerical activities rather than crafts' in the light workshop and to assess for domestic rehabilitation in the kitchen/bedroom suite.

The trend of Physiotherapy treatment was to be 'more towards re-education of function through active treatment over short periods then longer term passive treatment'.

Approximately 6 sessions/week by 2 doctors in the adjacent outpatients department were intended to provide for most consulting and clinical procedures although some injections, ice and wax treatments and heat/light treatment would take place in the appropriate treatment cubicles and rooms.

There would be a senior Occupational therapist and a superintending Physiotherapist responsible in tandem with the Consultant Rheumatologist and any other designated consultants, for the organisation and administration of the department.

A majority of inpatients would be seen and treated at ward level; outpatients would come by appointment to use the facilities provided; this procedure varies slightly for Occupational Therapy.

PURPOSE, FUNCTION AND ADMINISTRATION

The unit takes a broad mixture of inpatients, especially in the mornings, and devotes about half the workshop space to approximately 10 patients from psychiatry. Medical consultants refer hemiplegics and neurological-disease patients to the department and some orthopaedic patients are able to attend and use the facilities as well. However, many of the latter are seen by Occupational Therapists on the ward, where 'treatments' (Activities of Daily Living) are also started. A number of patients are given further support at home after discharge.

Work on the surgical wards is also carried out (though on a less regular basis) mainly for elderly patients.

'Work' on the wards consists of assessing the ability of patients to cope with essential personal care - such as getting in and out of beds, dressing and washing: Assessment for aids is also made and these are issued on loan from the hospital. Bath-aids and toilet-frames would be requested from the Social Services and the Occupational Therapists maintain a good contact with the local Social Service workers throughout the period of treatment.

The mixture of psychiatric patients with others during morning (or afternoon) sessions is seen as reasonable so long as individuals are fully informed of the constitution of the group and the reason for the exercises.

The only problems have occured where head-injury cases have suffered personality changes and find group-orientation difficult in any case.

A good deal of the work really comes under rehabilitation rather than under 'diversional therapy', although the latter designation might be used say for patients staying over 3 weeks in the hospital.

Close observation is kept on all community and social factors which would influence the success of rehabilitation and in many cases the Disablement Resettlement Officer is able to help.

Clerical and gardening work (the latter causing some friction with the Works Department) is encouraged particularly in view of the rural nature of the catchment area.

Although the provision of a workshop is necessary to assess people's manipulative and endurance abilities, it is felt that both working areas (the greater part of the unit) were designed for a somewhat out-of-date policy of 'occupation' only rather than for assessment and rehabilitation; this situation seems to typify the general misconception about the role of occupational therapy.

Contacts with consultants are generally quite good and the occupational therapists are encouraged to go on ward-rounds.

The pattern of referral for outpatients is to come through a consultant. GP's also follow this procedure when sending patients 'up'.

The addition of the new Geriatric Block at Bury necessitates the staffing of its day centre with Occupational Therapists. This department was set up without reference to either the present Occupational Therapy or Psychology departments

(who are not represented on any planning committees) and at present no official communication or rationalisation of function between the old and new departments is being encouraged.

Records were originally meant to be kept in the Physiotherapy department, but this was too far away, so they are now duplicated with one set held in the OT's office and the other in Medical Records.

Housekeeping is now only part-time and because of the automatic problems of keeping the area clean around the machines, some cleaning is now done by staff.

Security and losses of tools have caused problems but the situation has improved since staff started locking the department at night.

The department is also used for teaching Occupational Therapy students.

WORKLOAD AND STAFFING

No precise breakdown of patients treated was available, although it was estimated that approximately 50% of the users are psychiatric patients. Only a small proportion are outpatients.

The daily workload of 100 patients (given in the policies) is thought to be ridiculous; very few people come in for less than one hour and for most people it is necessary to give them a day's continuous treatment.

The kitchen/bathroom suite is considered inadequate and poorly designed, enabling only two patients at a time to use the facilities. Some patients are treated by a Physiotherapist and Occupational Therapist working together.

Staffing levels at present stand at:

Physical Medicine Dept	(OT Supervisor (Basic grade OT (Aides (Voluntary workers	1) assessment and 3) rehabilitation work 2) craft work etc ?) (variable)
Psychiatry	Occupational Therapist	1
Geriatric Block	- ditto -	? (not known)

The departments are considered to be understaffed in qualified and senior staff, but staff are encouraged to move between Physical Medicine and Psychiatry to rationalise the workload.

ACCOMMODATION

Office space is considered adequate but not good for holding confidential conversations (acoustically poor) - it is used mainly for coffee. The department is well sited and integrates well with Physiotherapy, however, Psychiatry is thought rather far away for communications between OT staff in an emergency.

The single large OT area in Psychiatry is considered 'hopeless' because it is too open and there is no provision for clerical rehabilitation or 1:1 therapy/ discussions.

The workshops are reasonable in size for groups up to 10, but there is a need (locally) for a proper rehabilitative 'Industrial Workshop'.

It is considered pyschologically beneficial to bring orthopaedic (traction) patients into the department, but circulation space is a little confined - they have even had two beds wheeled into the kitchen area. This area as such is inadequately equipped to undertake realistic exercises in rehabilitation apart from cooking, and in any case it is thought better to carry out such activities in the patients' homes where possible, although the Occupational Therapist would like an attached unit where rehabilitation patients could actually stay overnight and learn to cope domestically.

Conclusively the figures given in the policies for patients using the facilities in both Physical Medicine and Psychiatry were unrealistic and far more individual or small workspaces are needed.

Finally, not enough thought was put into planning an area externally where very useful 'therapeutic horticulture' could take place.

ENVIRONMENT AND ENGINEERING

Few comments were made. They include:

1. The problem of bumpy lifts for orthopaedic and other patients coming down to attend the department.

2. Access and movement for disabled (wheelchair) people is very awkward in the hospital and details of width of doors and the strength of the door closers should be reconsidered.

3. A better access to the 'gardens' would have been appreciated.

4. The siting of the OT's office in between the light and heavy workshops renders any concentration or conversation impossible owing to excessive noise all round.

OTHER

The NHS reorganisation has caused problems of communication and representation at DMT level; on Health Care Planning teams representation is poor and is thought to be a result of reorganisation.

TREATMENT AND DIAGNOSTIC SERVICES FRIMLEY
DEPARTMENT OF PHYSICAL MEDICINE: OCCUPATIONAL THERAPY

PURPOSE, FUNCTION AND ADMINISTRATION

The unit at Frimley accepts (in addition to the normal mix of Psychiatric and in-patients) quite a number of children, for whom the facilities are not entirely appropriate.

A lot of the work of the unit extends into the community using the hospital as a base and approximately 50% of the patients doing activities-for-daily-living (ADL) are also followed up at home so that necessary improvements or community help can be arranged.

The acute pattern of care of the hospital with its quick throughput of patients is thought useful by the staff in persuading the GP's and the community services to examine the referrals to Occupational Therapy and to take a keen interest

in the after-care (upon discharge). Referral cards are used and the doctor/consultant is asked to specify the nature and purpose of the treatment.

The Physiotherapists and social workers are also kept in close contact with the treatments and the nature of work of the department, but it is felt that relations could be better between the staff in Physical Medicine.

Visitors and relatives are encouraged to come and find out about the implications of a particular illness and its treatment, although there are sometimes too many of them, and the unit tends to get crowded particularly in the afternoons.

It is felt that the back-up facilities in the community are poor and that many more day centres should be persuaded to take patients so that they don't deteriorate. The unit could then function as a back-up medical facility and would be able to review such as multiple sclerosis patients on a much more regular basis.

The pattern of referral is to accept mainly from consultants (and only occasionally from GP's) but it is felt that an enormous amount of work could be done for GP's if sufficient community services were available (for post-treatment back-up).

Orthopaedic patients are assessed post-operatively, but the design of the bedroom area is not suitable for such procedures, being too public and awkwardly arranged.

The housekeeping is shared between the Geriatric Ward and this department, and although some cleaning has to be done by staff there seem to be no major problems.

Security has proved a problem and now the department is locked by the staff at nights.

WORKLOAD AND STAFFING

Very little information was available on the types of treatments, the types of patients and the number of staff required: however the staffing levels appear to be up to establishment and only extensively modified treatments would requiree further staff.

The workload consists mainly in dealing with urgency or geriatric cases - all on a programme of rehabilitation - and a smaller proportion (say 10%) of Psychiatric patients.

ACCOMMODATION

The area presenting the greatest shortage of space is the (ADL) kitchen/bedroom suite, at least twice this area appears to be required.

The staff room is considered important although maintaining confidentiality remains a general acoustic problem. It is very important that the patient can feel psychologically that he is talking in private, and the structure does not help.

ENVIRONMENT AND ENGINEERING

Generally the environment, the fittings and the overall functioning of the spaces has been reasonably satisfactory. Certain points have been made and include:

1 Noise in the workshops and the lack of confidentiality in the office due to poor acoustic properties of the structure etc,

2 Finishes articles are no longer part of the objectives of treatment (this concept is out of date) so the store set aside for them is not required.

3 The kitchen/bedroom area gives rise to a great deal of concern from the patients' point of view - mainly due to the standard of cleanliness, the slipperiness of the floors, and the odd arrangement for the screening-off of the bed which is neither practical as it is, nor is it applicable to any situation likely to be faced in the patient's home.

4 There are insufficient pieces of proper rehabilitative equipment such as the detachable bicycle fitment which enables the patient/user to safely position him/herself before and after using the lathe (or whatever)

OTHER

A great impedence to the success of the rehabilitative procedures carried out in the hospital is thought to have been caused by insufficient assessment of the developing needs of the catchment area of the hospital.

The department is thought to be well sited, but many staff are still remote mentally and physically from the functions and possibilities of use of the unit.

The 'Health and Safety at Work Act' might well affect the procedures carried out in the unit, but it is felt that all work habits and environmental conditions should be openly discussed.

NHS reorganisation has affected the department at a senior staffing level, particularly in the Psychiatry department where the position of the person in charge is constantly changing.

TREATMENT AND DIAGNOSTIC SERVICES: BURY ST EDMUNDS
DEPARTMENT OF PHYSICAL MEDICINE: PHYSIOTHERAPY

PURPOSE, FUNCTION AND ADMINISTRATION

The functions of this department follow the outlines given in the policies with the majority of patients being allocated to a particular Physiotherapist.

In the first instance, an assessment for the need for physiotherapy is made by a GP who refers the patient to the consultant in OPD for a decision on whether treatment is necessary. The patient may have to wait several weeks or longer between this assessment and being admitted by appointment to Physical Medicine department, so a third assessment is carried out (as the symptoms or condition of the patient may have changed) by the Physiotherapy staff.

Daily assessment and treatment are carried out in a single cubicle as often as possible; however, the staff prefer to treat the CVA/stroke patients in the open exercise area as it is possible to use low plinths rather than the high couches (the patient's sense of balance is often poor).

The consultant rheumatologist was originally expected to carry out the intermediate assessment within the Physiotherapy department including all out-patients and GP referrals. This didn't work and an appropriate clinic has now been al-

located in OPD. A lot of the rheumatologist's work necessitates immediate diagnosis and treatment and only a small proportion of patients are referred to Physiotherapy. The one treatment which the rheumatologist does carry out in the department is electromyography, which is carried out in what was designated as an interview room. Treatment Room 1 is used for ultra-violet treatment and Treatment Room 2 is used as a ward-cubicle for treating ulcers.

The Physiotherapy superintendant thinks that the policy of everyone changing is a 'little outdated'. The majority of patients use the cubicles to remove as much clothing as is necessary - the accent is on individual rather than group treatment. The gym is used infrequently for knee-injury and 'heavy-workout' sessions - generally only by men. As a result the female changing rooms are not used for patients, but are allocated as staff facilities.

There is not a great deal of contact between this section and the Occupational Therapists, although the latter do a certain amount of splint-making for the Physiotherapists. Not a great many patients are passed from one to the other.

WORKLOAD AND STAFFING

No exact figures were available on the numbers of patients being treated, but it was felt that despite the problems of patients being on waiting-lists, the system meant that time appropriate to a patient's needs could be allocated at the time of the third assessment before treatment was begun. Quite often the workload shifts considerably from one type of patient to another and this will affect staff availability and the use of space (eg they may have a number of CVA patients at one time and then none for six months).

No exact figures were available on staff numbers but three senior Physiotherapists, responsible for Orthopaedics, ITU and Geriatrics have a number of basis-grade Physiotherapists allocated to them. Only the junior staff rotate their work routines.

ACCOMMODATION

There were numerous comments:

1 The exercise area was felt to be too small for the inclusion of plinths and standard bars.

2 The number of cubicles could have been increased.

3 A hydrotherapy pool was not provided, but its inclusion would benefit orthopaedic, neurological and disseminated sclerosis cases, in particular relieving the effect of gravity. A 15' x 12' pool would be required.

4 No proper lockable storage room was provided for the large delicate instruments and machines. The lack of locks - security in general - has proved a great problem and the incidence of theft from the department has been very high.

5 The accommodation of and provision of the correct type of wheelchairs has been a particular problem in this department. They are needed for CVA and hemiplegic patients.

6 The provision of a gym is not thought to be essential as the types of treatment do not involve group work. Staff do not like working in it because they are very much cut-off from other staff and any help. Part of this problem is due to the lack of nearby alarm signals. Because of the dangers of patient collapse, staff will not work alone in the gym and two working teams don't always coincide to make its use worthwhile.

7 Extra storage space is needed for ventilators and for large numbers of walking-aids (because they can only be ordered in large numbers).

8 The positioning of the department with its own front entrance is felt to be reasonable but the access to it from the rest of the hospital, through OPD is confusing, congested and inconvenient.

ENVIRONMENT AND ENGINEERING

The problem of storage space for equipment is endorsed by all staff. A lot of objects are simply propped up in the corridors.

The problem of poor positioning of the emergency call buttons and lights has worried all staff. Unless you constantly look up 'you can't see if a patient is summoning assistance' or 'if a member of staff needs help ... this is bad'. There is not even a buzzer-repeater or indicator in the superintendant's office.

OTHER

It is not felt that NHSS reorganisation has had much effect.

Security and access to the department from the first floor at night have presented the biggest problems.

It is felt that the coffee/snack bar is too far away for both patients and staff. A beverage point would have been useful.

TREATMENT AND DIAGNOSTIC SERVICES FRIMLEY
DEPARTMENT OF PHYSICAL MEDICINE: PHYSIOTHERAPY

PURPOSE FUNCTION AND ADMINISTRATION

The Physiotherapy unit follows the functions outlined in the policies in many ways, taking mainly outpatient referrals and some direct from GP's. In-patient referrals are usually orthopaedic or rheumatology cases who are referred by the appropriate consultant.

The department was opened during a 'mammoth' exercise when most of the other local facilities closed. Staff had to be absorbed from other units and the exercise meant a re-adjustment psychologically and job-wise for a majority of them. Some patients also had to reorientate (mainly in altering their travel arrangements) and they now usually come by appointment.

Work on the wards is usually restricted to undertaking bed-bound exercises, except that the Physiotherapists like to treat all CVA patients in the wards. Other patients are encouraged to come down to the department - even in their beds - this includes a number of orthopaedic patients.

The majority of patients from the orthopaedic/fracture clinic are also referred to Physiotherapy.

Other patients, such as geriatric and psychiatric patients, are treated in their own departments.

Medical record and X-ray facilities are often required in this unit and for such purposes access via the outpatients department is felt to be rather congested.

There don't appear to be any problems with control of infection - one or two open wounds are treated and the occasional TB patient is treated. Occasionally patients are sent to the Central Treatment Suite, but dressings are normally done within the department.

The average waiting-list time for consultant referrals is 2-3 days, for GP referrals is 3-4 weeks and inpatients don't wait, as they are seen in the wards.

WORKLOAD AND STAFFING

The shortage of cubicles is thought to influence the numbers of patients that are passing through the unit. There are only 13 cubicles and the staff could use about 24.

The workload from the inpatient departments is higher than was anticipated and a total staffing establishment of 14.5 (7 working in the Physical Medicine Department - the rest on the wards) is required.

ACCOMMODATION

The main comments about accommodation concerned the provision of a hydrotherapy pool which is being planned at the moment (at a cost of £72,000). It would be used for the majority of patients and would be particularly useful for early rehabilitation exercises for hip replacement patients. A 14' x 20' pool would have been ideal - the actual pool is likely to be 12' x 14'. The new unit will include its own changing facilities, showers, a utility room, linen storage, a wheelchair WC and good access to cubicles sited adjacent (semi-open) and to the rest of the unit.

ENVIRONMENT AND ENGINEERING

Thee were several comments:

1 Although the unit has its own intermittent positive pressure ventilators (mobile), there is a need to use oxygen cylinders and it would have been useful to have had oxygen or piped air supplied.

2 The alarm system is satisfactory for the cubicles, but is considered inadequate for the gym and for the two single treatment rooms.

3 Temperatures (solar gain) have been a problem with record levels reaching 85F/29C and it seems that sun blinds or louvres cannot be supplied.

4 Acoustic problems in the interview room and offices have caused considerable difficulties in holding confidential conversations.

5 Electric plug-socket outlets have proved inadequate in number and have been poorly positioned. This problem has been particularly exasperating in the wax-room where the wax-bath and ice-machine cannot be run simultaneously because of overloading the system.

OTHER

A number of other comments include the effects of the pattern of care which is felt to have worsened since the catchment area population expanded far beyond the planning estimates.

The other major problem as at Bury St Edmunds has been that of security and easy access to the department at night. The loss of bandages, equipment and other items has been very high.

TREATMENT AND DIAGNOSTIC SERVICES CONCLUSIONS
DEPARTMENT OF PHYSICAL MEDICINE

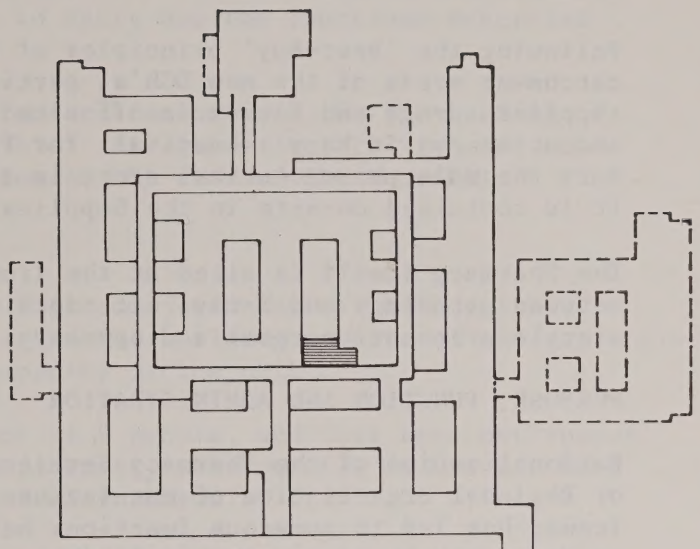
This section has been written up in greater detail than most, because it was felt that insufficient knowledge of the functions of the department - partic ularly those of Occupational Therapy - had been shown in the Planning Policies*.

A lot of people in other departments still remain very ignorant about the possibilities of use of the department and those who do use it often hold somewhat 'out-of-date 'ideas about the effectiveness of the treatments that can be offered.

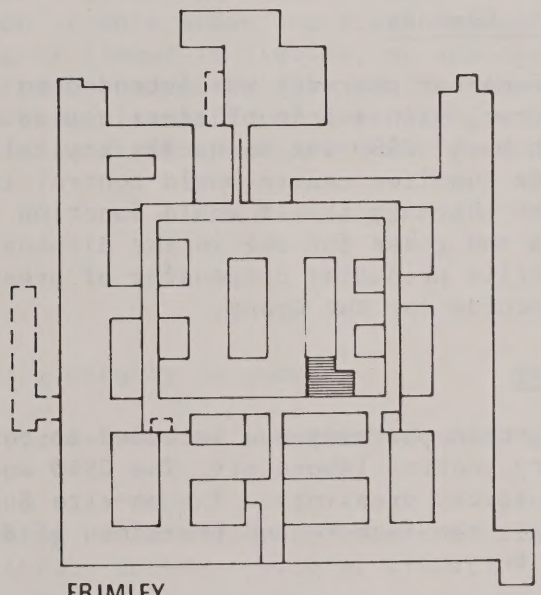
The department offers unique facilities for the co-ordination of progressive patient care and part of its function is to encourage the continuity of treatment or care between departments and into the community, but a shortage of accessible day-centres in the locality can reduce its effectiveness. It is a pity that certain internal communication problems impede the usefulness of the units, particularly where lack of representation is the cause. The units appear to work closely and fulfil the functions of the policies, but it is felt that the estimates of users were 'impractical' and that more cubicles for Phsyiotherapy and more small rooms for Occupational Therapy would have been very useful.

*National design guidance on OT was still in a formative stage at the time of planning.

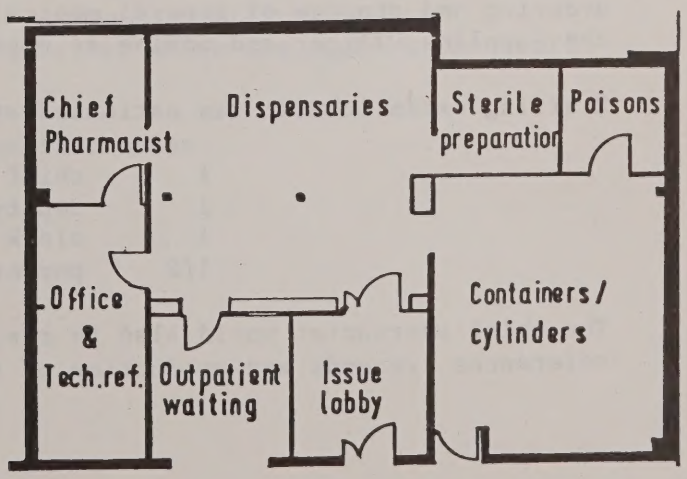
Pharmacy.



BURY ST EDMUNDS



FRIMLEY



PHARMACY

This section contains general information and commentary on the policies for off-sited services, and on the development and expansion of the departments.

LOCATION AND DESCRIPTION

Following the 'Best-Buy' principles of optimising the activities within the catchment areas of the new DGH's, partial manufacturing and stocking of supplies, drugs and fluids is off-sited. For Bury this occurs at Newmarket and at nearby St Mary's hospital: for Frimley this occurs at Farnham. In Bury the main pharmaceutical store is sited at St Mary's hospital; in Frimley it is contained on-site in the Supplies Centre at the back of the hospital.

The Pharmacy itself is sited at the front of the inside of the hospital street between pathology and X-ray. It contains a large containers/cylinders store,and sterile preparation room, a dispensary, a waiting and issue area, and two offices.

PURPOSE, FUNCTION AND ADMINISTRATION

Rationalisation of the Pharmacy Services at each DGH, in context with the Area or Regional organisation of manufacture and supply of drugs, fluids and other items, has led to numerous functions being planned off-sited - in Bury's case at Newmarket Pharmacy, St Mary's (Bury St Edmunds) CSSD, and in the on-site DGH Supplies Centre; and in Frimley's case at the Farnham pharmacy and CSSD, and in the on-site DGH Supplies Centre.

Bury St Edmunds

The Newmarket pharmacy was intended to contain bulk storage, manufacture and breakdown, main supply of sterile products and quality control laboratory. The St Mary' CSSD was to handle topical fluids and surgical dressings. The on-site supplies centre would control in and out handling of gas cylinders, and the pharmacy itself would function for subsidiary day-to-day drugs storage; fluids and gases for use in the dispensary and elsewhere: emergency preparation of sterile products: dispensing of prescriptions for all patients: administration and records for the Group.

Frimley

The Farnham pharmacy was intended to contain the main supply of sterile products, quality control laboratory. The CSSD would control the supply of topical fluids and surgical dressings. The on-site Supplies Centre would provide for bulk storage, manufacture and breakdown of drugs and the Pharmacy itself would function as at Bury.

At neither hospital would the chief pharmacist be directly responsible for the ordering and storage of general medical supplies, but he would 'liaise with the Supplies Officer and advise as necessary on quality and technical aspects'.

Staffing establishment was estimated at:

1	chief pharmacist
1	deputy pharmacist
1	clerk
1/2	porters

The chief pharmacist would also be responsible for the up-keep of technical references, records and production of statistics.

PURPOSE, FUNCTION AND ADMINISTRATION

Since the catchment-area has been reorganised and the hospital and its extensions have been fully commissioned it has been found that in the accommodation provided, it has been impossible to carry out the functions described in the policy.

Division of the service into 3 areas is unsatisfactory and the pre-packing of tablets within the pharmacy is not possible. All these factors have led to pressure for a separate pharmacy extension at the rear of the hospital.

WORKLOAD AND STAFFING

As has been mentioned the impact of the full commissioning of the hospital, plus the reliance of community referrals and the building on-site of the geriatric extension, has overloaded the working capacity of the unit.

There is at present a staff establishment of 9 people, and this does not appear to leave any allowance for holidays and sickness, consequently it has not been possible to start a much desired ward-pharmacy scheme.

ACCOMMODATION

The area provided appears to be 'woefully lacking' and the direct access to stores within the department was considered essential. The pattern of work flow is poor, and the lack of segregation of work areas, worktops and no provision for waste and disposal, for the handling of flammable liquids, or storage for intra-venous fluids means that the department cannot fulfil its functions, cannot follow the BSI guidance on storage, and cannot satisfy the fire officer and others implementing legal requirements for working space, circulation and means of escape.

ENVIRONMENT

Three problems are predominant:

1 The daylighting/artificial lighting generally is poor.

2 The ventilation is poor and necessitates awkward measures to allow the staff enough air.

3 Particles from the ceiling are tending to fall into or onto the medicines, making working procedures and conditions rather trying at times.

OTHER - DEVELOPMENT AND CHANGE

It has been the legislation of the Medicines Act which has enabled the staff to press for departmental expansion.

The new accommodation will have three specific areas:

One for pre-packing of tablets.
One for small-scale manufacturing.
One for bottle washing.

PURPOSE, FUNCTION AND ADMINISTRATION

For the purposes set-up in the policies both the size and the shape of the department appear to be wrong. The department generally is too small, and is lacking in support services.

The original functional assessment has also proved to be incorrect, as the stores/quality control area should also have been on-sited at the DGH.

WORKLOAD AND STAFFING

Statistics available in the department have shown a 216% increase in the workload within 3 years.

The original staffing figures given were estimated to have a daily output of 3,000 units, the present output is approximately 12,000 units/day.

A rationalisation of the stock system within the department was carried out in order to make it possible to work with the staff and space provided.

ACCOMMODATION

The space available has been 'lacking' in many respects. It has been found impossible to produce sterile goods in the designated area.

No strong-room or alarm system has been provided.

More space and equipment is needed for refrigeration.

The autoclave room could not be used as no positive pressure was provided in it, and it is at present used as an emergency store. A sterile products room is to be built onto the hospital.

The washing-up area was difficult to operate, and it was in any case found to be cheaper to throw away all bottles upon return.

The main work room has been made functional by removing the shelving and thus providing a free central area for trolleys and staff.

Room for holding information, for teaching and for any privacy is totally lacking, and no space was provided for an emergency drugstore-essential for night use.

ENVIRONMENT

Apart from workspaces being awkward and too small, the quality of air/ventilation and lighting have caused the biggest problems, and have necessitated the addition of windows from the corridor.

OTHER

Although gradual innovation and changes made in the department have produced a much more efficient working environment it is still not possible to implement all the requirements of the 'Medicines Act' and further rationalisation will be necessary.

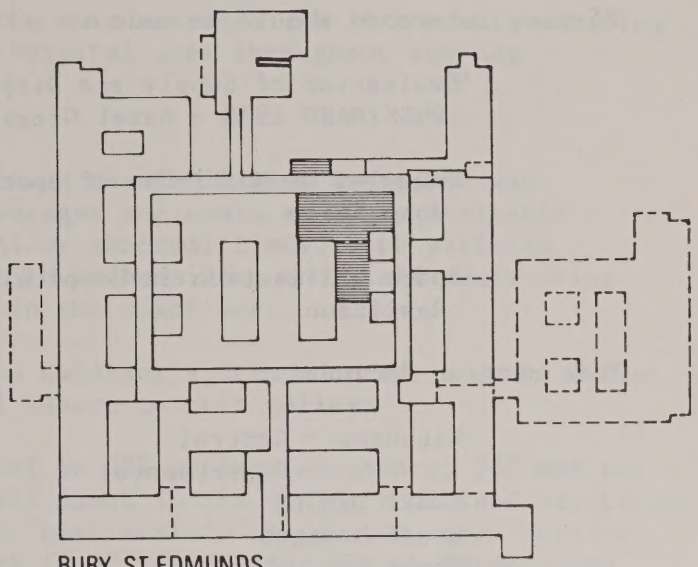
The Pharmacy service, its organisation and accommodation and the so-called 'rationalisation' - all rather hazily outlined in the planning policies - has failed in many ways and coupled with the legislation of the 'Health and Safety at Work Act' the 'Medicines Act' and the 'Fire Precautions Act' has been very difficult to implement effectively.

Space saving has caused considerable difficulties, and has necessitated expensive extensions at Bury St Edmunds.

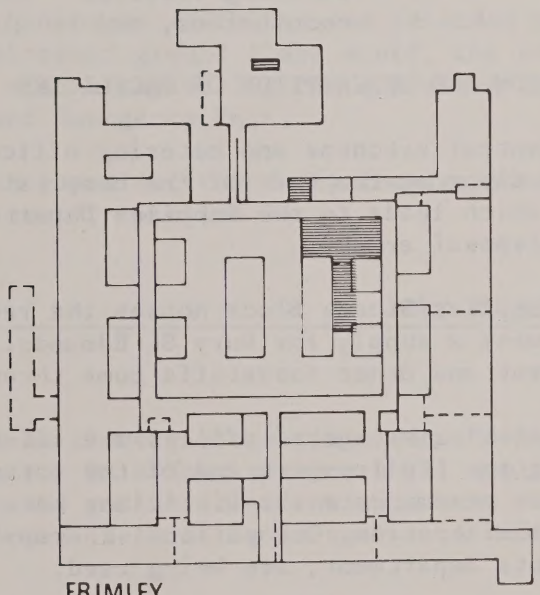
It is a department which needs further studies into activity data and work-flow patterns.

The use of the Frimley Pharmacy shows how a careful look at management systems and resulting organisation has resulted in a remarkably good working solution (given the conditions), by a skilled pharmacist.

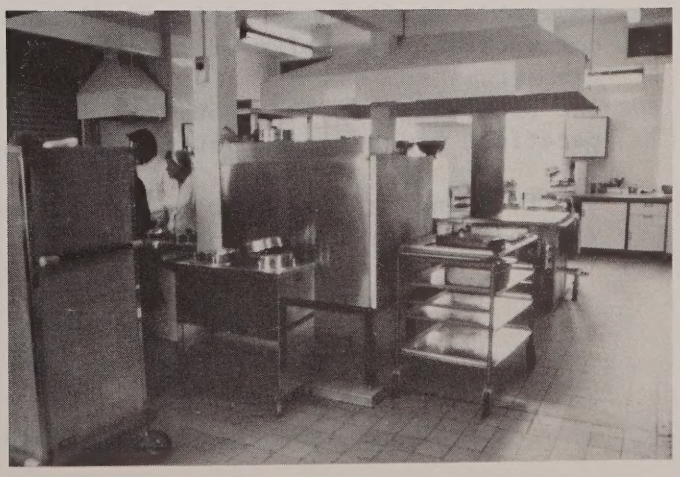
Catering & Dietetics.



BURY ST EDMUNDS



FRIMLEY



NOTE: Owing to the recent detailed evaluation of the Best Buy Catering departments by the DHSS (see 'References') this section will only deal briefly with the departments and services concerned, following the general format of the report.

Further reference should be made to :

'Evaluation of Supply and Disposal Systems in Best Buy Hospitals' DHSS/MARU 1978 - Hazel Grayson

'Examples of Multi-Use of Space in Hospitals' MARU 1977 - John Kelly

'Space Utilisation in Hospitals' MARU 1977 - Dr Carole Rawlinson

This section includes :

Kitchens - Central
- Departmental
Staff Dining
Staff Lounges
Snack Bar

NOTE: For explanation of some terms used to describe the Catering Services - refer to planning policies, conclusions, and to glossary.

LOCATION AND DESCRIPTION OF FACILITIES

The Central kitchens and catering offices at both hospitals are located on the first floor at the rear of the hospital with nearby access to the top of the ramp which leads to the Supplies Department (deliveries, stores, distribution and disposal areas).

The Supplies/Stores Block houses the reception cold rooms, the provision store (one week's supply for Bury St Edmunds, one month's supply for Frimley) and all meat and other foodstuffs come through this entrance.

The Catering Managers' offices are situated in a small block off the street, facing the trolley-park end of the catering department. Provision has been made to accommodate the Dieticians here, but at both hospitals other offices in Administration, Occupational Therapy (Physical Medicine) and in the Out-patients department, are being used.

Two small serveries are included in the psychiatric and geriatric departments to enable staff to portion and distribute the patients' meals. In the link corridors to sets of wards are beverage points.

The new Geriatric block built at Bury St Edmunds has necessitated a new preparation, kitchen and distribution system sited within that unit.

Staff Dining is located between the Central Kitchens and ITU and has the provisional use of a roof-top terrace.

Below the Stores Area of the Central kitchens, at ground floor level, is the Staff Lounge - connected by trolley and hoist to the beverages preparation area of the kitchens.

Other Staff lounges are situated in the Education department and at Bury beneath the gymnasium and at Frimley in Administration adjacent to the staff changing entrance and also in the separate social block near the residences.

The Snack Bar is located en-suite with the main entrance and is the only catering facility available to all categories of hospital user throughout the day.

PURPOSE, FUNCTION AND ADMINISTRATION

The objective of the Catering department and the facilities described was intended to ensure that all types of beverages and meals would be available to patients, staff and visitors at normal or abnormal times, with patients meals being served in the dayrooms or at their bedsides, and staff meals being available in the central dining room or in the snack bar.

With a certain amount of variation in the Catering system adopted, and the extent of service provided, the hospitals still adhere to this policy.

The assessed need for the 553 bed hospital at 85% patient occupancy, 75% medical and nursing usage, and 40% ancillary staff usage in the dining room (and additional use of the snack bar) totalled 1,593 for 'main meals'. A 'plated meal' service for the first floor adult wards and "bulk food" service for the children's and ground floor wards - all by heated trolleys - were to be delivered by portering staff to the entrances and thence distributed by ward staff to the patients.

In addition to its regular function the concourse snack bar was intended to provide trolley services for departmental-bound ground floor staff, the education centre lounges and the Committee Room; also occasionally the operating department staff via the direct hoist link to Day and Emergency Unit.

The total catering staffing complement intended for the fully commissioned hospital, inclusive of 7 reserve (pool) staff, totalled 94.

CATERING AND DIETETICS BURY ST EDMUNDS

PURPOSE, FUNCTION, ADMINISTRATION

The policies outlined have been followed as closely as possible but the bulk-food service has been found unsatisfactory. Bulk-food service still applies to the ground floor wards, except on the new geriatric extension, where despite the insufficient kitchen space, a plated-meal service is in operation and works well.

Planning the service and the kitchens took account only of the use of 'convenience' foods (see policy), and this has proved to be totally impractical. As a result traditional food preparation and cooking is now taking place and the equipment, the drainage, the space and the layout of the kitchens are unsatisfactory.

Training of three trainee cooks at a time is carried out, and again the policies failed to anticipate this requirement.

The "Health and Safety at Work Act" is causing considerable concern in the Catering Department and also, or perhaps because of it, considerable time is taken up with staff union problems.

The snack bar appears to be a great success, and at night it is manned full time by an assistant cook and a helper. A microwave oven has been installed to help prepare speedy light meals.

WORKLOADS AND STAFFING

It is felt that in the present accommodation and layout, because of the expansion of various departments the workload will be approaching a maximum and that crisis situations could occur if the demands for catering are increased.

In the community, St Mary's Hospital provides 90 meals on wheels per week, supplementing the WRVS's own distribution service.

Within the dgh the main kitchen provides:

900 main meals for 350 staff
550 patients (including 20 day patients)

The new geriatric kitchen provides:

110 main meals for inpatients and day patients.

(There are 2 "main meals"/day).

MANAGEMENT

The management of the department is compared with the establishment in the policy:

POLICY	ACTUAL	ESTABLISHMENT/GRADE
1	0	Group Catering Manager
1	1	Hospital Catering Manager
1	2	Assistant Catering Managers
1	1	Clerk
1	3 + 2	Independent diet aides

Geriatric Extension (WestSuffolk d.g.h)

	2	Assistant head cooks
	2	Cooks
	1	Assistant cook
	2	Kitchen Porters
	3	Kitchen assistants
	4	Cafeteria assistants

West Suffolk d.g.h

18	equivalent	18	Cooks
3	"	8	Kitchen porters
8	"	6	Kitchen assistants
0	"	4	Trainee cooks
60	"	43	Cafeteria assistants

ACCOMMODATION: DEVELOPMENT AND CHANGE

As has been mentioned the expansion of the hospital has affected the catering service, in particular, in having to implement a separate catering service for the new geriatric block.

It is felt that should the expansion continue the piecemeal development of new kitchens to cater for such demand would be less satisfactory than a total restructuring (physically) and reorganisation of the catering department in its present location. Despite this, however, the new geriatric kitchen appears to be working well.

With the existing central accommodation there is a very high rate of dissatisfaction. Many omissions in rooms accommodation have occurred, but the most serious defect is that the present layout is convoluted, causing much congestion and the workflows do not appear to have been arranged in any logical order. Several changes of use of storage and preparation areas do not seem to have solved this problem.

(One must, however, bear in mind that the kitchens were not designed to accommodate bulk storage and mass preparation of food).

The layout around the storage, butchery, cooking and frying areas is causing the greatest staff dissatisfaction which is resulting in a high turnover of staff.

ENVIRONMENT/ENGINEERING

Two problems are dominant from the staff point of view:- equipment has not proved very satisfactory to handle or operate - in particular the dishwasher has caused certain problems - and the trolleys are not spacious enough to take completed patients trays. Ventilation problems appear to be very serious, although it was the snack bar rather than the kitchens which suffered owing to "close" conditions in the snack preparation area and excessive smoke in the general seating areas.

Daylighting in the kitchens is good and the outlook from all dining facilities is excellent and very much appreciated by all staff and visitors.

OTHER

Although access to and the relationship of the kitchens from supplies is reasonable there are certain problems of queueing of trolleys and the efficient disposal of waste, both of which are affected by the distance from catering department down the ramp to the disposal area.

The other problem mentioned was the rather high rate of infection in the catering department which has been causing general concern.

PURPOSE,FUNCTION,ADMINISTRATION

Because "convenience" foods have to be used to a large extent in the catering department here, perhaps insufficient space was allocated for the numbers of freezers within the department. This has led to the workflows remaining convoluted because of reallocation of spaces, uses and functions.

The service supplied to most wards is a "tray service". Exceptions to this are geriatric and psychiatric wards on the ground floor (G2, G3, G4) which have a "plated meal service", and the isolation and childrens wards (G1, F1) which have a "bulk food service".

The layout and service of the department as described in the policies might have been acceptable if the catchment area had remained at a low level, but the high occupancy and turnover of the patient load and the influx of greater numbers of staff has caused considerable problems in maintaining the service, whilst leaving enough time for proper kitchen maintenance and cleaning.

The lounges, dining areas and snack bar appear to function well except for the relative overcrowding of the former and latter at peak times of day.

Only one catering assistant is on duty at night in the snack bar which does not provide a sufficiently satisfactory area for night nursing staff.

WORKLOAD AND STAFFING

There is an apparent tendency, in staff eating habits, to prefer lighter or cheaper meals. This is beginning to affect the workload and the service provided. The number of main mid-day meals/day stands at :-

Patients ...	480 - 520	(plated)
	30 - 40	(bulk)
Staff ...	220 - 260	

The snack bar caters for approximately 130 people/hour between 9am and 5pm. The coffee lounge caters for between 80-90 people/hour between 9am and 5pm.

The management and staffing of the department and service is as follows:

POLICY	ACTUAL	
1	1	Unit Catering Manager
1	1	Assistant Unit Catering Manager
1	2	Dietician
1	1 (2 part time)	Clerk
-	1	Typist
1	1.2	Kitchen Superintendent
1	1.2	Head cook
2	3.4	Assistant head cook
6	8.15	Cook
7	6	Assistant/Trainee cooks
3	7.5	Kitchen porter
1	1	Senior supervisor
58 equiv	40	Catering assistants
7	4.5	Relief Staff

ACCOMMODATION

Particular mention was made of the lack of space provided for deep-freezers in the department.

The wash-up facilities and space proved inadequate and had to be extended; this has brought only partial improvement.

The demolition of the staff rest room for this purpose, coupled with the removal of tightly planned staff wc's, now means that there are no general staff facilities within the kitchen area.

Both in the Kitchens and in the snackbar no disposal room was provided. This is felt to be a serious omission.

Other dining, coffee and snack facilities appear to be satisfactory and much appreciated, although overcrowded at times.

ENVIRONMENT/ENGINEERING

The two aspects that have not been particularly satisfactory in all catering areas have been the provision of inadequately designed ventilation and the difficulties of cleaning around and underneath equipment. As at Bury St Edmunds, the additional lack of provision of grease traps in the drainage systems has caused considerable problems and is a nuisance and a potential health hazard to the rest of the hospital.

OTHER

There is a certain amount of concern in the Occupational Health Centre about the rate of illness or infection contracted by catering staff. As yet no bacteriological tests have been made of food or equipment, so it is dificult to ascertain how serious the problem is, or what is the cause.

CATERING AND DIETETICS — CONCLUSIONS

Whilst Frimley have been able to manipulate conditions to some extent in order to follow the guidance, if not the detail of the policies, the situation at Bury St Edmunds has proved substantially difficult due to the impossible supplies problems occurring when convenience foods are relied upon. Part of this problem may be due to the very small area allocated in the Stores/Supplies block at the rear of the hospital, for "convenience" provisions. Although the same store at Frimley has been increased in size and is still overflowing because of lack of space, the monthly rather than weekly stocks seem to facilitate caterers' ordering and do not cause the same problem.

However, this does mean that important assumptions about space and organisation in the policies were very misleading and the planning of the department around convenience foods has neither been worked out well in detail, nor has it allowed essential reallocation of space functions to be carried out in a satisfactory or flexible manner.

Certain concern at both hospitals was registered over the distance between the catering department and the supplies and disposal areas at the other end of the ramp. This has led to clustering of dirty trolleys in the hospital street, to spillage around them and to certain difficulties in moving loaded trolleys (because of weight and ease of manipulation) from one level to another.

Also because of the distance between the reception area of food in the supplies block and the catering department, the chefs often find it time consuming, unhygienic and difficult to walk away from their work to check incoming supplies.

On "development and change" the experience at Bury St Edmunds has shown that there may be a need to reorganise the service and layout of the central kitchen (perhaps in its existing position) which might well mean expanding into the staff dining and other areas. Peripheral kitchens have worked well but whether it is cost effective to supply virtually a duplicate catering service each time a large departmental development occurs, is debatable.

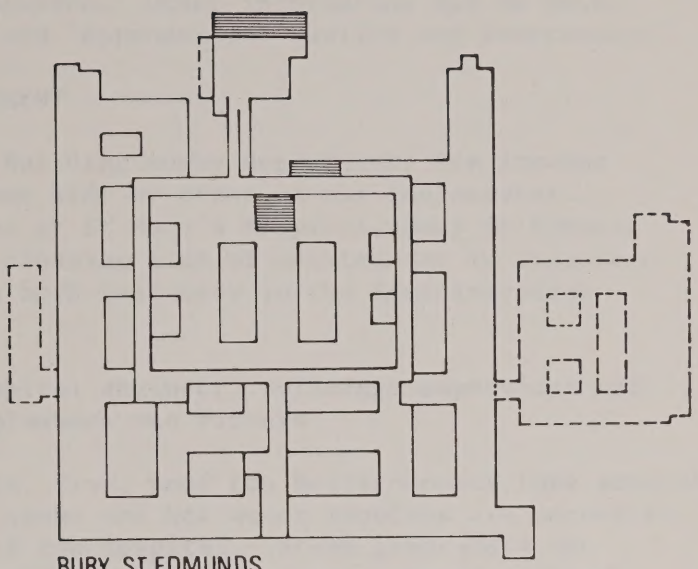
Other catering facilities have received detailed attention in other studies concerning frequency of use (ie snack bar, dining areas, coffee lounges). It is pertinent to point out that these areas have successfully mixed staff and have been well placed to provide pleasant visual and psychological relief from the stresses of hospital activity and routine.

It is sad that more staff facilities for meeting, discussion and relaxation were not provided in the first instance. The potential for multi-purpose and extended hours use is obvious.

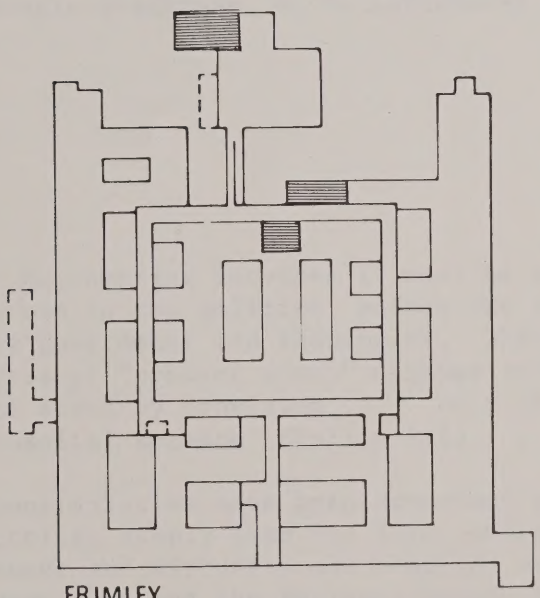
One point of concern is the high rates of infection or illness of catering staff in both hospitals. Particular emphasis should be taken to research the causes of this, particularly in relation to workflow, maintenance and cleaning and layout of the main kitchens and the pattern of work adopted in each.

Night duty dining was never properly detailed and the result is that the partial use of the snack bar is thought unsuitable because meals and variety of beverages are not sufficient, the space is used by other people amongst whom the night staff find it difficult to relax, and anyway they feel somewhat remote from other staffed areas.

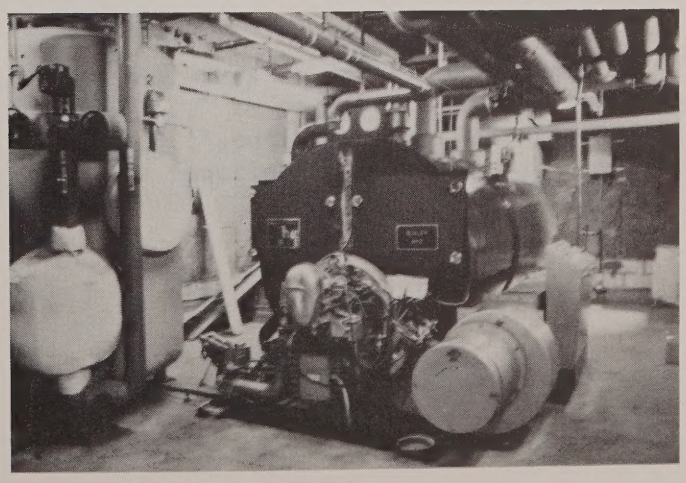
Engineering, Works, Maintenance, Disposal



BURY ST EDMUNDS



FRIMLEY



ENGINEERING, WORKS, MAINTENANCE AND DISPOSAL

This section contains notes on Maintenance, Cleaning and Disposal as appropriate to the Policies on 'Engineering' and 'Works'. For detailed information on Cleaning refer to the section on 'Housekeeping'. For detailed information about Disposal refer to MARU/DHSS report 'Evaluation of Supply and Disposal Systems in Best Buy Hospitals' 1978 by Hazel Grayson. Other information may be found under 'Administration', 'Conclusions' and 'Appendix 1 - Quality and Environment'.

LOCATION AND DESCRIPTION OF THE DEPARTMENT

In both hospitals the Engineering and Building works departments are located in the rear of the Supplies Block to one side or other of the incinerator. The District Works Officers are located at St Mary's Hospital, Bury St Edmunds and at Farnborough near Frimley. The cleaning side of maintenance is organised by the Housekeeping manager located in both instances in the Administration area.

The works accommodation houses the hospital engineer, buildings supervisor and their staff of painters, carpenters, plumbers and fitters.

At Frimley, four and at Bury St Edmunds, five, roof top boiler-houses (one separate above the Geriatric Block) plus water tanks and hot water supplies are connected to ring mains which circuits the top of the hospital. Steam generators are sited off-site, at the CSSDs and Laundries only. Individual generator units are provided for TSSU, Pathology and the Catering Department washer-units.

Access to the roof-top is by central single staircase, or by catladders only.

PURPOSE, FUNCTION AND ADMINISTRATION

Engineering

Before launching into detail about the Engineering Services it must be borne in mind that they were set-up, as depicted in the policies, before the advent of the current attitudes and actions by government and industries. These latter have markedly affected both the 'criteria of "present worth" economy and ease of maintenance', and the duplication or stand-by provision ... ' only in cases where breakdown would impair a vital hospital service' (Policy 11B).

Because so many of the Engineer's responsibilities have been concerned with calibration of and maintenance of electrical supply (and its fire control), which governs the use of the boiler-houses and virtually all hospital equipment, there have been concerted efforts between them and the Regional Health Authorities to remove the stand-by part-supply (25% or less of maximum demandload) and install a complete covering stand-by system of generators.

This is an essential change of the Engineering Services in order to maintain other responsibilities outlined in the policies ...' to regulate all environmental conditions within the hospital' ... maintaining ...'specialised aspects of patient care and treatment' .... and permitting ... 'the functioning of other supporting departments and services'.

These points are emphasised because it has proved a completely false economy to provide stand-by services covering such proportions of the hospital for such a small amount of time. While this accorded with national policy in those days it has since needed considerable modification. At present it would be nearly impossible to run the hospitals for more than 2/3 days should main supply be cut off.

In brief, the hospital Engineer is responsible for maintaining the following services: heating mains and media - in this case warm or conditioned air and low pressure hot water; domestic hot and cold water and drainage; ventilation and air-conditioning; mechanical and electrical equipment and hospital fittings and fixtures; gas, medical gases and electrical supplies; lighting, communications, noise control and alarm systems.

Works and Maintenance

'Works' covers the variety of skilled, semi-skilled and labour trades and people required to maintain the functioning of 'working parts' of the hospital.

The 'Group Engineer' in both cases (originally responsible for all maintenance, engineering and works) is now replaced by a number of people responsible for maintaining the services at either District or DGH level.

The roles and responsibilities of these personnel at Bury do not match those at Frimley, but both teams ultimately must communicate and involve central administration or its representatives when any work in any department is required (ie all supportive work or maintenance).

Under the Works Officers and the Hospital Engineer, a system of planned preventive maintenance is supposed to be in operation to 'provide an effective insurance against the risk of sudden breakdowns disrupting vital functions of the hospital'. To some extent this policy is carried out, and the total staffing requirement for this increasing sophistication of skills required to maintain equipment which cannot be contracted-out to the suppliers for maintenance is beginning to affect the stability of this system (see 'Conclusions').

The functions of general maintenance extend beyond the normal duties of the housekeeping staff. This means that both nursing and housekeeping staff are at present supposed to (and in future will be legally required - under the 'Health and Safety at Work Act') inform the Works department of defects and requisition for replacements of items of equipment, furniture, fabrics, fittings and fixtures.

'Manufacturers and suppliers of specialised equipment are expected to cover the regular inspection and maintenance of their products' (Policy 11C), but in fact this rarely happens as planned, and as has already been noted the skills required of works-staff to undertake such tasks are increasingly under demand.

Disposal

This aspect of hospital functioning is always very complex, and it was planned to make maximum use of the siting of the Services/Supply Block and the trolley/ 'floats' system by removing all portable waste including linen, in colour coded bags via the Supplies Block either to laundry for reprocessing, or to the Central Incinerator - located adjacent to the Engineers/Builders rooms, or to external bins and storage areas.

other waste is disposed of directly or via suitable equipment into the usual drainage system. The change in operational policy of several departments since commissioning has adversely affected the main drainage in particular (see 'Conclusions').

The management and control of disposal is jointly the responsiblity of Administration, Housekeeping, Portering, Engineers, Works personnel and the Control of Infection Officer. It demands a great amount of communication between those who use and those who service the hospital in order for the system not to break down. The biggest implication is the training and education of staff and users at Ward/departmental level to co-operate in bagging waste correctly, in turn supported by reliable service from the above-mentioned service personnel.

Increasingly, the external (to hospital) pressures on the system will be caused by greater use of disposable and plastic goods.

The siting of Mortuary, Isolation, Catering and TSSU departments to the rear of the hospital near to the disposal areas - thus avoiding use of the 'busier streets' - is justified in policy and in practice.

ENGINEERING, WORKS, MAINTENANCE AND DISPOSAL BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

In addition to the functions described in the preceding preamble the Engineering Department acts as a right-hand for the Works Department in supervising all works carried out at the DGH including drainage maintenance, grounds and gardening supervision, and the repair or replacement of many pieces of equipment, fixtures, fittings and fabric. In this respect the Works Department as such appears a little top-heavy in management, but it must be remembered that various independent works teams in the District need to be supervised (particularly at St Mary's Hospital) and that expansion and development of the DGH will necessitate a cohesive logistical Works/Planning team.

'Fabric' and 'Drainage' are causing considerable problems for the Works/Engineering departments (see 'Conclusions').

WORKLOAD AND STAFFING

Four problems are causing the workload to fluctuate:

a. the persistant recurring drainage problems and the difficulties of getting maintenance staff into the internal manholes safely, at a time that will not disrupt communications and functioning along the hospital streets etc.

b. ventilation: in various areas the design of ventilation plant or the assumptions about natural ventilation have been very inadequate; in particular such areas are the Snack Bar, Pay Ofice, Psychiatry Kitchen, Pathology - whole department, Central Delivery, ITU and Central Treatment Suite. Particularly the latter group have required additional cooling.

c. ducting: this has caused much wastage of time owing to the contorted and dangerous procedures involved in getting at control valves, and the inability to isolate them, or switch off current.

d. the increasing requirement for hospital works/engineering staff to be able to maintain, adapt or replace complicated equipment themselves at short-notice.

The TSSU autoclave steam generators are an example of a particularly ill-conceived concept which is now necessitating the removal, re-siting and redesign of such plant.

Staffing levels appear to be acceptable but again, as and when the hospital expands, a strain will be put on the services unless further skilled or semi-skilled staff can be engaged.

ACCOMMODATION

The work spaces in the rear of the Supplies Block are rather curiously long and narrow, but seem to be slightly larger than those at Frimley.

Storage of broken articles awaiting repair is the biggest problem, despite what was stated in the policies.

ENVIRONMENT/ENGINEERING - DETAILS

Heating generally is satisfactory to the patients, whilst it has been some bother to the staff. The problem is that there were few isolating valves and the zoning of services is poor. 'The design was perfect as long as it went on working - when anything goes wrong I'd have to shut down a large section of the hospital'.

Hot water control is poor on the bidets,and has deterred a lot of people from using these valuable fittings.

The use of more electrical equipment over the years has put an enormous toll on the supply system - all over the hospital. Maximum demand stands at present at 580 KVA and the replacement stand-by generators capacity is only 500 KVA.

Lighting at night is difficult to adjust to acceptable levels; although bed-head lights are equipped with dimmers they are not used much, and the only means of lighting the very dark wards (except by switching total illumination on) is to switch the WC lights on and leave the door ajar.

The fire alarm system and its zoning is unsatisfactory - even having been already replaced once.

ENGINEERING, WORKS, MAINTENANCE AND DISPOSAL — FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

In contrast to Bury St Edmunds, the grounds and other similar maintenance are not covered by the hospital Engineer here, but by Buildings/Works department under the general control of the District Works Officer.

Additional to the staff occupying the Engineering department is a resident drainage engineer - his presence is required because of persistant drainage problems.

The Engineering department has tried to follow a system of planned preventive maintenance but has discovered that unless the many pieces of equipment are commissioned properly, the policy becomes impossible to follow and continual crises can occur because equipment has been installed incorrectly. This has put a strain on the skills and availability of staff and is only now being brought under control.

The Engineer has been able to establish good rapport with staff in most departments and is making sensible design changes to items such as ward night-lighting, the fire alarm system and the emergency call system etc.

WORKLOAD AND STAFFING

All the detailed problem concerning the demand on staff workload and skills are as applicable here as they were at Bury.

There is not the same extent of hospital expansion as at Bury, but at present the staffing levels are considered only just adequate. They stand at:

Hospital Engineer	10/11 Craftsmen
2 Assistant Engineers	(3 semi-skilled on shift work)
Secretary	(3 Grade 4 fitters)
Drainage Engineer	(5 Electricians - 4 full time)
Building/Works Supervisor	

ACCOMMODATION

The accommodation for Engineering/Works staff at the rear of the Supplies Block appears to be limited and poorly designed. Two engineering staff occupy the staff rest room, but there is a female staff WC nearby, unlike Bury.

Obvious space shortages include a room for design engineering, more space for the electricians and of course storage of materials coming in, and for all items awaiting repair. Modest improvements are in hand.

ENVIRONMENT/ENGINEERING - DETAILS

The low pressure hot water heating system appears to be very acceptable, but there are problems of temperature building up in the ring-main (roof top) which would not occur with steam. Maintenance access for all roof-top services needs improving.

Steam is really required in TSSU and theatres, also for the washers etc in Catering. Changes in Catering operational policy have caused problems with drainage, and a great loading on the major supplies of services to that area.

Again the rapidly increasing load on the electrical capacity of the generating plant - due to more departmental equipment and personal acquisition of electrical goods by the resident staff - has put an unforseen load on the system, the maximum demand on some days reaching 600 KVA.

Lighting in the streets was putting a very heavy load on supplies and now photo-cells have been installed to control the level of illumination. Changes in night lighting have been made and now at periodic intervals along the length of all first floor wards retractable ceiling-hung 'dining-table' lights have been installed and are proving very successful.

The fire alarm system is not satisfactory (telephone) and a break-glass system would have been preferred. However, the fire alarm zoning is being made to coincide with the fire compartments in order to establish some consistency.

DEVELOPMENT AND CHANGE

It is clear that as the hospitals - particularly Bury in the near future - change and move or extend departments, the Engineering, Works and Maintenance staff will be fully stretched to cope with all the demands made upon their time, skills and knowledge, and ability and flexibility of attitude to working around or in cramped and sometimes dangerous conditions. Much of this could have been avoided if elements such as well-designed ductwork had not been upset by convenienc planning, preventing by cost-implication the 'Best Buy' from being 'Best Buy'.

As a result of such measures as that, and say the poor robustness and performance of the 'Durox' Structure (except as a heat retainer) and the lack of protection of fittings and surfaces, the maintenance cost and 'revenue-cost' implications are enormous. It is a pity that such factors should mar what is otherwise a very well appreciated environment - but the criticism comes from everyone.

DISPOSAL. INCINERATION

The biggest concern here is the change to greater amounts of plastic waste, and consequently the embarrassment of the nearness of the incinerator plant to the main hospital. The resultant increase in output of smut and ash may be overcome by modified burners such as Frimley now have installed. Because of the increased quantities of waste being collected, many bags have to be dumped outside the hospital at the back - posing an unsightly and potentially dangerous source of litter and infection.

The engineering staff at both hospitals are not happy with the make of disposable bed-pan washers used, and because the units are not operated at night (because of the noise) waste stockpiles unpleasantly in the disposal rooms, and excessive use of the machines early in the morning is causing odour to remain and the machines tend to fail.

COURTYARDS, GARDENS

These will be dealt with in some detail in 'Appendix 1 - Quality and Environment'.

It appears that the control or supervision of the gardening and landscaping by engineering staff at Bury - although seemingly incongruous - works quite well, and the Frimley staff seem also to favour this. Much depends on the individuals involved and the involvement of housekeeping and portering staff is to be recommended.

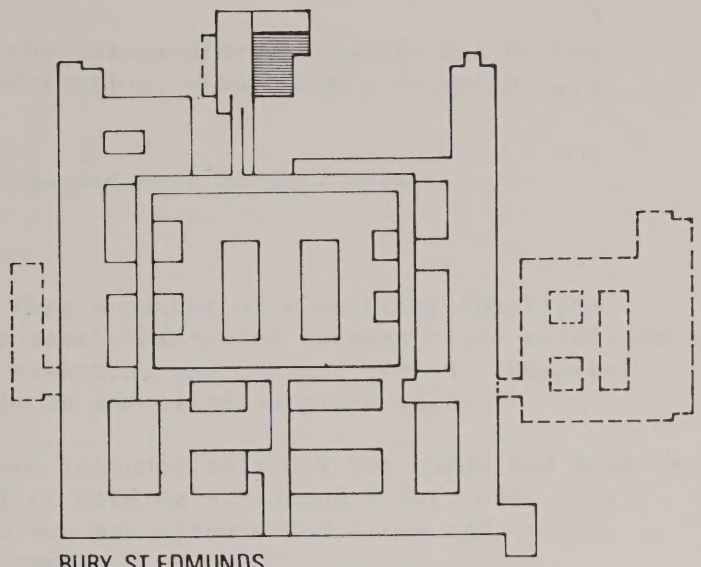
Given a chance, the courtyards at Frimley could flourish as well as those at Bury (with on-site staff undertaking some of the work) ... they already provide a sanctuary for sleeping pied-wagtails at night ... and could accommodate more people during the day time.

OTHER

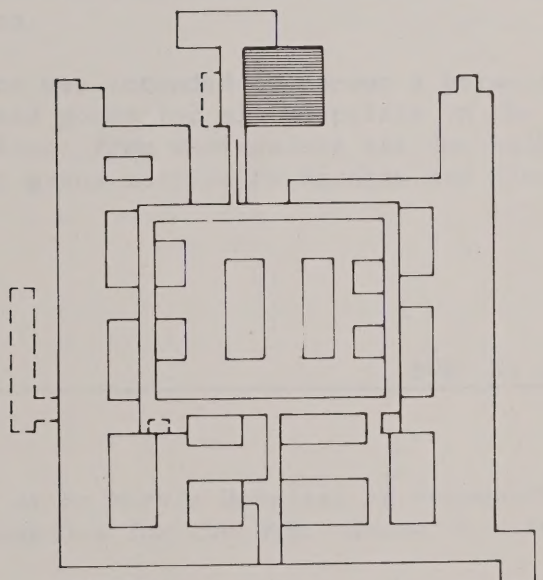
Communications and co-operation between all levels of hospital staff would enable the Engineers to work more effectively. Countinuity of staff-responsibility, or more organised requisitioning of items needing attention might help.

Refer also to 'Housekeeping' and 'Administration'.

Supplies, Storage & Distribution.



BURY ST EDMUNDS



FRIMLEY

SUPPLIES : STORAGE : DISTRIBUTION

LOCATION AND DESCRIPTION OF DEPARTMENT

The on-sited supplies/stores blocks at Bury St Edmunds and Frimley are located at the rear of each hospital, connected by two-way ramp to ground and first floors.

They are amalagamated with meter rooms, the incinerator, engineers and builders departments, with CSSD reception and distribution, with Laundry reception and disposal, and with Catering suplies.

In addition, at Frimley the Pharmacy stores are held in this area.

PURPOSE, FUNCTION AND ADMINISTRATION

It was assumed in the Planning Policies that a number of supporting functions (mostly 'industrial') would be wholly or partly off-sited because close relationship with DGH patient-care functions was not essential and because several hospital or health facilities could be served from an off-sited supplies unit.

Both supplies blocks at the hospitals were intended to stock the wards and departments on a day-to-day basis of topping-up, whilst holding a maximum 5 day cover supply for weekends and holidays. The distribution was planned for a tug and trolley system reaching both hospital floors by ramp.

At Bury St Edmunds, topping-up for all supplies using local and central supply points was part of the pipe-line from the built-in reserve stocks, which would be bulk stored and broken down at Fulborn.

At Frimley, the Farnham 'industrial' zone was intended to become a prime distributor of certain 'manufactured' and re-processed goods for all hospitals in the group, but the DGH would receive many stocks direct from wholesalers etc for bulk storage and breakdown and would provide a normal group service to Farnham and Fleet hospitals.

SUPPLIES — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The district supplies manager off-sited at St Mary's Hospital is responsible for ordering but does not control the supplies for the DGH. There is a storekeeper manager on site at the DGH.

Pharmacy store is organised separately on a part-time basis off-sited at St Mary's (2 kilometres from the DGH) and a secure holding bay is incorporated in the off-sited supplies block to accommodate pharmacy deliveries.

The stores block at St Mary's was built as a sub-area depot (possibly because of the loss of Fulborn in NHS reorganisation) and now relates directly to Ipswich. It supplies some GP practices, clinics and district health personnel.

Hospitals in the District are:

Newmarket, Thetford Cottage Hospital, St Leonards, Walnutree, Risbridge and Jane Walker.

Health Centres include:

Woolpit Health Centre and Bury St Edmunds Health Centre.

Health Clinics include:

Sudbury, Haverhill, Newmarket, Mildenhall,Thetford. (Most have family planning clinics)

The stores/supplies at St Mary's are now stocked and maintain the on-sited stores block with one week's provisions at any time.

Topping up at the DGH was supposed to have been implemented but due to lack of co-ordination in overall management, and certain staff difficulties, there is a type of requisitioning system employed on a weekly basis to most wards and departments.

Exceptions to the 3-tier Area/District/Unit bulk breakdown and supply system are:

1 Disposable bedpans and urinals which are delivered for topping up direct to the ward's 'sluice-rooms'.

2 Medicines - which are delivered direct to Pharmacy.

3 Pharmacy stores which are controlled by pharmacist and go direct to Pharmacy.

4 Building materials other than light bulbs and tubes which are under the control of the District Works Officer - this includes equipment which is ordered through Ipswich.

WORKLOAD, STAFFING AND REQUISITIONING

There are approximately 6 staff on site and several at the bulk stores at St Mary's. There is a District Supplies Manager, and there is also a nurse representi supplies in the divisional Team who facilitates communication with nursing and medical personnel and management.

Because there is a certain amount of stacking of CSSD stores in the on-site stores block, 2 trained staff are now engaged in sorting-out specialised supply requirements 'en-route' between CSSD and departments.

There are problems in ordering from industrial contractors because of the rural area and geographical position of the hospital, but there is plenty of space in the off-sited supplies store to breakdown bulk initially. However, items tend to be sent on to the hospital for final breakdown as requisitioned.

The system used is part requisitioning, part top-up, which is monitored by storekeeping staff doing the rounds of the wards every week.

Department/Ward staff requisition from:

Hospital Store (5 days supply - for CSSD see appropriate section) who requisition from:

District Supplies - off-sited at St Mary's, who supply the hospital weekly or as required, with their own transport fleet.

The off-sited stores hold a large number of items and are trying to standardise the packs of supplies to the hospital.

ACCOMMODATION

Deliveries:

Following extension of the on-site Stores/Supplies Block, deliveries and return items now come to both 'ends', mainly catering and general stores to the storage loading bay, mainly CSSD and laundry to the other end. The stores loading dock has folding sliding shutter doors which work well, but tend to remain open for most of the day. (They are designed well, but heavy to operate). As a result the narrow receiving plinth is open to the weather and also receives damage from the transport lorries.

The narrow passage (over the in-situ weighing machine) already congested and cluttered with boxes, chairs and other items unable to be stored elsewhere in the hospital becomes a circuitous route to be taken for all deliveries. Items still arrive in bulk.

Storage:

There are numerous different types of light caged trolleys which ferry goods between entrance and racks. The entrance loading bay consequently becomes even more crowded. The stores area is generally cramped and there is not sufficient working space.

The shelving is well-lit and works well, but wider shelving is needed to cope with the wide boxes in which goods still arrive. Breaking down of items occurs upon requisition, not before, to some extent. Wooden benches installed at the time of commissioning do not seem as useful as shelving, and there are not proper desks or stationery racks to facilitate clerking in the stores area. Some items (disposable syringes etc) are stored here; others temporarily stored in the dirty laundry collection bay are transfered from time to time to a small locked room on the other side of the ramp.

Catering supplies (supposedly 4 days dried and tinned goods) are held in this area, and a small cold room has been created out of two even smaller cold rooms to hold other special provisions. This room is already at capacity, and will not cope with further demand upon hospital expansion.

Despite the supply philosophy, the provision for catering supplies is still cramped and insufficient. But the main problems are bulk items and poor circulation routes.

Distribution:

The roller shutters to the ramp/trolley area are not used and benches have been set against them. The concrete plinth beneath the shutters prevents through access for trolleys that are brought into the area to be loaded with boxed supplies.

The tug-trolley system and the ramp seem very satisfactory, although there can be some congestion at the stores end of the ramp, and the supplies circulation routes conflict with the disposal routes.

ENGINEERING, ENVIRONMENT ETC

Points concerning the poor and exposed design of the loading dock have already been described. Heating is not entirely even in distribution.

Daylighting is excellent but the fluorescent tubes have been installed at right angles both to shelves and to the northlighting and the lighting pattern that results is rather disturbing.

One sink in the stores area appears to be sufficient, and the removal of the two in the provisions store (catering) would have made more space for benches/ shelves.

The conditions for temporary delivery and holding of CSSD supplies are not entirely satisfactory when dirty linen and other goods are occupying and passing though the same area.

OTHER

Please refer to 'Laundry', 'CSSD', 'Disposal - incinerator' and 'Engineering' for other comments affecting this area.

SUPPLIES FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

General Community:

The manager works under the overall jurisdiction of the Area Manager (as assistant to District Suppliers Officer) and is responsible for a District distribution - carried out in area batch-delivery by the Farnham transport fleet.

Hospitals in the district:

Brookwood, Farnham, Fleet, Frimley Children's Central Outpatients and Northfield.

Health Centres include:

Aldershot, Yateley, Farnham and Camberley.

Health Clinics (some Family Planning) include:

Ash Clinic, Berkshire Road, Frimley Park, Aldershot, Farnham, Camberley, Yateley, Farnborough Grange, Cove Manor and Fleet dental clinic.

Others:

Farnham nurses home, Farnham Child Guidance, Chobham Surgery and Lightwater Surgery.

FRIMLEY PARK HOSPITAL

As opposed to Bury St Edmunds, the Frimley supplies department has been set up as a part District supplies and distribution department on-site.

This affects the function of the unit, particularly regarding availability of supplies at any time to any department in the DGH. As a result, the rota for departmental supply has been organised principally around a two weekly requisitionin system (rather than a topping up system) with the departments grouped into three groups. The third group, namely Operating Theatres, ITU, Accident and Emergency, Ward F11B (Post Natal) and Central Treatment Rooms requisition and receive supplies on a weekly basis.

The two other groups are:

Group A (First Floor)	Ward F1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11A, Day and Emergency, Central Delivery Suite, TSSU and Special Care Baby Unit.

Group B (mainly ground Floor)	Wards G1, 2, 3, 4, X-Ray Department, Pharmacy, Physiotherapy, Nurse-education, Pathology, Obstetric Clinic, Housekeeping, Kitchens (Catering Department) and OPD.

WORKLOAD, STAFFING AND REQUISITIONING

The workload appears to be increasing and in common with other hospitals, there is the problem of equating bulk orders (a necessity) with the typical requisition quantities and special requirements. Bulk breakdown has to take place here and causes space problems.

Some of the 10 staff are being trained to know the speciality requirements, but the workload is such that more experienced staff (with previous sorting experience) are of more use than recruits.

Colour-coding by district (sub-group) and by day, is used for sorting in the loading bay, and for stacking and dispatching.

Special requisition forms are checked with order books and orders are made up in tubs, in advance, to be loaded onto the wire cage trolleys that move around the hospital.

ACCOMMODATION

Deliveries:

All deliveries except laundry and CSSD call at the bell-push and are accepted through shutters to the off-loading area. Pharmacy stores are governed and checked by a full time pharmacy storeman. The loading area can be very cold and slippery in bad weather, and the vertical roller shutters are time consuming and dangerous to operate.

There is no external cover to the shutter entrances, and the fascia pieces at the head of each opening are not sufficiently high to avoid damage from tall lorries.

Storage:

Rollers and low trolleys are used to move boxes and items to the well daylit rack areas. The circulation appears to be well delineated, but the space between racks has been decreased and should not be decreased any further.

Various depth racks are used, but there is frustration that either two-storey or sub-ground level accommodation was not provided to relieve the congested shelves. An area adjacent to the ramp, facing Psychiatry was suggested as a suitable site for a lightweight bulk store.

Keys to the storage area are kept with the Sector Administrator in case of fire, and with the Stores Manager.

Distribution:

The through loading roller shutters adjacent to the ramp are not used and have shelves against them. Trolley tugs enter the department and are loaded with the prepared tubs before distributing to the rest of the hospital via the ramps.

Catering supplies are also held in this area and deliveries must be inspected daily and weighed here by the chef and a Catering Manager before passing through to the fridges in the Catering Department. About 4 days dried/tinned goods are held here.

There appear to be no difficulties with this organisation.

ENGINEERING/ENVIRONMENT

Lighting is good but the heating system is noisy. The entrance bays are poorly designed, preventing good working conditions through wind, cold and slipperiness on the floor near the buffer.

A tea club provides much needed beverages adjacent to the staff sink, this works well.

All other environmental aspects appear to be satisfactory.

OTHER

Please note the commentary on CSSD and Laundry sited at Farnham and refer to the section on Development and Change in 'Conclusions'.

SUPPLIES : STORAGE : DISTRIBUTION CONCLUSIONS

The Planning Policies envisaged a 'topping up' system for both hospitals. This has never worked, except very patchily where only the disposable bed-pans and urinals are distributed thus (plus sterile supplies at Bury St Edmunds).

The system used generally involves requisitioning, and a well devised if somewhat rigid system is being applied at Frimley, where the stores also act as a District Supplies base for various clinics and health centres.

In both areas, nobody envisaged a number of important issues which are still causing considerable organisational and space-provision difficulties; they include:

1 Mis-ordering from industry and the supply and storage in bulk at both hospital despite the policies.

2 Transport problems where unsuitable trolleys and loads cause damage, both inside and outside the hospital.

3 The rate of loss of stored items (which may reflect a national trend) which is approaching 10% of all ordered items - this holds particularly true for CSSD supplies.

4 Management and training of stores staff - particularly regarding making up of special supplies.

5 Job delineation and individual attitudes to tasks. If all other conditions are fair, there are still problems about who does what, how and for how long. This is a complex issue and although it is not a priority problem in the Best Buy Hospitals, particularly the 'Health and Safety at Work Act' will affect operations of these two departments and may also reflect in the design details, such as the stacking height of shelves.

6 Another point is the impact in ward level bulk storage of use of more and more disposable items. However, there are signs that the system is not altogether satisfactory in all areas (they would prefer old-style bed pans in some cases etc).

Storage on the Wards:

This is sited, as planned, adjacent to the nurses stations.

Because the storage of all items is very much more open to all and sundry at ward/departmental level, it is a fair assumption that a large percentage of the losses occurs from here.

At ward level, the supply system is not entirely sufficient, but a certain amount of borrowing appears to take place from ward to ward, as and when necessary.

The design of the racking and shelves appears to be satisfactory but the cupboards present certain problems if shelf-interchangeability is required. It is frustrated by the different widths of cupboards/base units in the same area.

A recent impact upon storage at ward and departmental level is the vastly increased demand for portable equipment, and no space seems to have been set aside for medical gas bottles which clutter floors or stand away from the areas where they are likely to be used.

Hospital Departmental Development:

In terms of on-site storage areas, both at Frimley and at Bury St Edmunds, no expansion of departments was envisaged, although other policies vaguely outline such tendencies. With both storage/supply blocks already stacked to capacity, there will need to be special logistical studies undertaken as and when development plans look like becoming a reality.

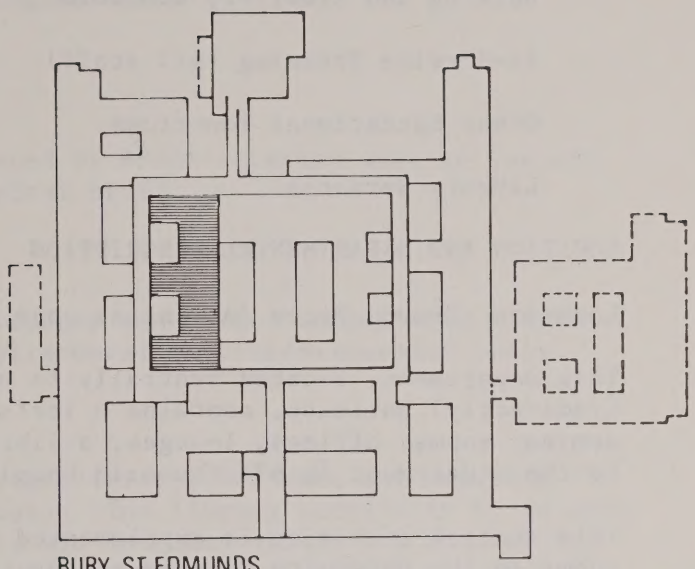
On-site delivery, storage and circulation of CSSD supplies and disposals should be rationalised.

Catering supplies and delivery of daily food supplies should be carefully assessed - the system is not entirely satisfactory now.

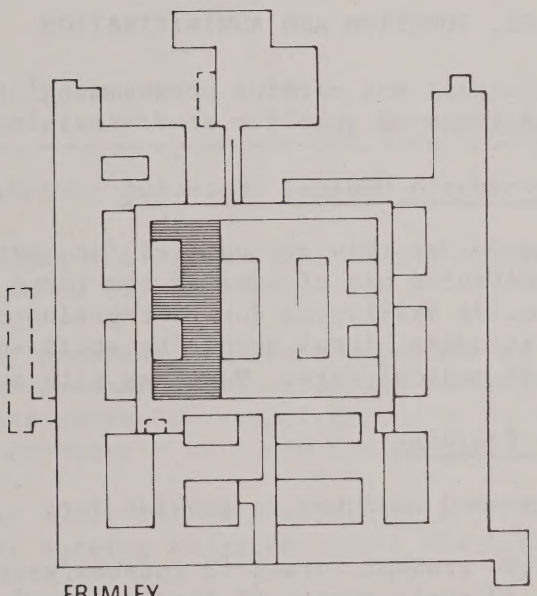
Generally, the supervision and control of the two storage areas would have been better if the manager's offices and the circulation routes had been re-considered. The offices could have been re-sited adjacent to the ramps, but this would now necessitate special daylight considerations.

These conclusions merely summarise the salient points of concern to both hospitals. For detailed analysis of both systems of supply (and disposal) refer to 'Evaluation of Supply and Disposal Systems in the Best Buy Hospitals' Hazel Grayson. Medical Architecture Research Unit/DHSS 1978.

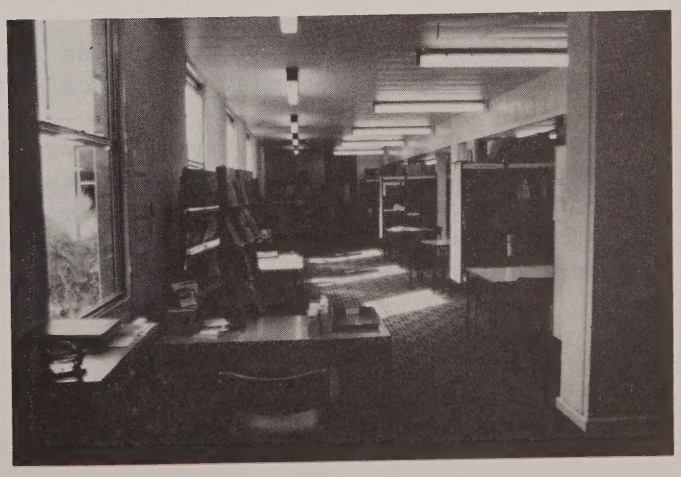
Education & Training.



BURY ST EDMUNDS



FRIMLEY



EDUCATION AND TRAINING

This section comprises:

Post Graduate Medical Education

Nursing and Midwifery Education

In-Service Training (all staff)

Other Educational Functions

Library Services

LOCATION AND DEPARTMENTAL DESCRIPTION

Location -Ground Floor in central core area.

This department, located centrally to serve all categories of staff and (indirectly) patients, contains a lecture room, practice and demonstration areas, seminar rooms, offices, lounges, a library and other ancillary spaces. Access to the department is off the main hospital ring-street through four main entrances.

This central provision is supplemented by ward seminar rooms, classrooms, tutorial rooms in the Maternity Department, by the flexible use of the hospital conference room and by other areas occasionally allocated for education and teaching use. In addition, the patient library trolley system is based in this area.

PURPOSE, FUNCTION AND ADMINISTRATION

By 'grouping and careful programming' the centre was designed to accommodate all sections of specific staff-training, 'in co-ordinated use'.

Post Graduate Medical Education

The needs for this are catered for, partly in exclusive accommodation and partly by timetabled use of some of the rooms used for nurse-training. The aim is to provide facilities for post-graduate education for hospital staff, general practitioners, local authority staff and members of other services contributing towards medical care. Meetings with and for other professions are also encouraged.

Nurse Training

The assumed need was to provide for:

150 student nurses (3 intakes/year)
50 pupil nurses (2 intakes/year)
40 pupil midwives (2 intakes/year)

The school was intended to provide for all theoretical and practical teaching for trainee nurses, post certificate and in-service training and study facilities.

Obstetric and Midwifery training was intended to centre in that department, but was to be encouraged in the use of the Education Centre. In addition 2 offices, a classroom, a seminar room, a periodicals study and milk demonstration rooms in wards and in the Obstetric (central block) facilities on the 1st floor, were to be available.

Also every consulting/examination room in the Obstetrics Out-patients (centre Ground Floor) was intended for daily ad hoc teaching and learning.

In-Service Training

The most likely users of the Education Centre were suggested as:

Administration and Clerical (including porters)
Technical Grades
Domestic and Catering Staff
Voluntary Organisations

These activities stimulated and co-ordinated by Administration were to include all induction courses for the entire hospital staff.

Other Education Functions

These include the use of the two Coffee Lounges and nurses common room - seen as adjuncts to the main Snack Bar - as extra-mural meeting/discussion areas.

Library Services

The patient's library is basically a storage library, but ambulant patients should have access to choose their own books. The library service is by trolley to the in-patients. The Reference library was intended mainly for all medical/nurse training, but also allowed for use by any authorised staff.

Separate study and research into Medical Records would be undertaken in that department.

EDUCATION AND TRAINING BURY ST EDMUNDS

PURPOSE, FUNCTION, ADMINISTRATION AND STAFFING

The Education Centre is still jointly managed and run for all representative groups, very much as envisaged in the Planning Policies.

Despite numerous environmental/engineering problems, flexible multi-use of space occurs but such tight organisation and the accommodation of future foreseeable changes in education patterns and needs has caused a special report to be written suggesting the removal of Nurse Training en-masse - to a new centre (see 'References').

At present, the post-graduate education is under the responsibility of a consultant physician (clinical tutor) and the nursing education under the Director of Nursing Education.

There is an establishment of:

6 tutors
2 pupil-nurse teachers
3 clinical teachers (including 2 SNO's)

in addition to which there is a Midwifery Education NO responsible via SNO (Community/Midwifery) direct to the District Nursing Officer.

There are:

3 secretaries (wte)
1 secretary (for District)
1 secretary (post-graduate)
1 Librarian

The 'Central Midwives Board', the 'Central Nursing Council', the 'Briggs Report' and the 'Health and Safety at Work Act' are all going to radically alter the type and use of accommodation and the numbers of people being trained per year. Some of this is a result of NHS re-organisation and the implications of EEC rules.

The present training figures are:

Trainee	No of intakes/year	Total (1978)
SRN	3	50
SEN	2	26
Midwife	4	24

It is thought that pressure will be mounted on the hospital to take 5-6 intakes (nurses)/year and that an 18 month block course in Midwifery might replace the intake system.

No figures were available for numbers of post-graduate medical students or GP's using the Education Centre, but it is known that nearly every GP in the locality has a practical link with the hospital.

ACCOMMODATION

At present, the accommodation appears to be satisfactory in content (if not in layout) for Medical Staff, but not for the Nursing Staff who are reviewing the scale of accommodation required for a new centre. Shared 'professional' use does not appear to be a problem - in fact many auxiliary functions would continue to be accommodated in a new centre; it is not entirely clear whether the new library envisaged would replace the existing one, or would accommodate only the nurse training need; however, the main needs appear to be:

1 Replacement demonstration rooms and practical rooms perhaps designed like the ward bays so that correct in-situ training could be provided for all grades of staff.

2 More office space to reduce incompatible or inconvenient sharing, to restore the ward seminar rooms to original use, to accommodate increasing staffing needs etc.

3 Replacement lecture-room that will function adequately for 100 people plus - including administration, ancillary staff, catering, housekeeping, pharmacy and medical meetings.

4 Tutorial/seminar/meeting rooms (1 or 2) for between 12 and 20 people including dietetics, housekeeping, social and voluntary services.

From the nurse-training aspect, the classrooms and practical/demonstration rooms could (and perhaps should) be re-arranged and in some cases enlarged and/or amalgamated (see special report 'References').

Finally it should be mentioned that the figures of Education Centre users, although not larger than expected in the policies, fluctuate radically, owing to the fact that the school provides District Nursing Education and owing to a tendency towards increased Community orientated use.

ENVIRONMENT AND ENGINEERING

The wrong layout or shape of the rooms has already been mentioned.

Two other problems connected particularly with the Lecture Theatre and the demonstration and practical rooms are the daylighting (lack of) and the ventilation (lack and/or poor control), both of which are chiefly responsible for real or strongly imagined symptoms of illness or fatigue. In addition, the columns in the practical room hinder sight and grouping of students and functionally impede room circulation considerably.

Other environmental aspects appear to be satisfactory except for the lack of confidentiality in the tutors shared office arrangements.

EDUCATION AND TRAINING FRIMLEY

PURPOSE, FUNCTION, ADMINISTRATION AND STAFFING

The Education Centre is intended to cater for all staff on a co-ordinated flexible basis for a number of rooms. In addition, the coffee lounges were to be run as adjuncts to the main snack bar and efforts are made to use them as such, particularly in their capacity as informal discussion areas.

Perhaps because of design impediments (in detail and in structure and layout) or perhaps because of complex organisational and managerial problems, and certainly because of un-planned-for numbers of users (total), there is a high rate of dissatisfaction with the policies and design of this Centre, from all concerned.

As a result the Post-graduate medical training facilities (although they include virtually total use of the library) appear to be grossly inadequate, and there are tentative plans - supported at Area level - to resite such facilities.

From the Post-graduate tutors' point of view, the total of those requiring and 'enjoying' the facilities of the Centre still grows, due to the unprecedented numbers of GP's and trainee graduates and medical students calling in (particularly at lunch-times) to attend lectures and short-courses.

Typical user requirements number:

approx 50 (resident) junior staff - covering all specialties.

approx 50 consultant staff.

approx 100-150 GP and trainee staff

Nursing Education

Conversely the Director of Nursing Education is having to restrict or cut down his intakes in order to maintain staff/student ratios at a level where satisfactory educational conditions can be met, the reasons being mainly economic.

Again due to General Nursing Council and EEC rules and other reports, pressure is being placed on the department concerning ratios and intakes.

The nurses are taken on in the following numbers:

Trainee	No of Intakes/year	Total (1978)
SRN	2	70
SEN	2	70
Midwife	4	24

The nursing figures being a 0.53 wte.

The number of tutors available - and indeed trained staff in the hospital - appears to be declining but the establishment figures for the Centre include:

1 Senior tutor
1 SNO senior tutor (allocation and statistics)
3 NO tutors
1 NO midwifery tutor (midwifery staff)
5 clinical teachers
3 Secretaries
1 Secretary (post-graduate staff)
1 Librarian
1 Nursing auxiliary (general and reprographic duties)

It was pointed out that factors external to the hospital were particularly affecting the organisation and administration of this department.

They include:

1 The national restructuring of the Nursing Organisation (Salmon) which whilst removing many trained nurses from ward base to administrative base still leaves a situation where too many trained nurses can't find appropriate jobs.

2 The mobility of the local population (army and air-force personnel) which necessitates nurses moving with their husbands more frequently.

3 The apparent decline in educational or (to be more exact) literal and numerical abilities of applicants to nurse training.

These factors appear to be of genuine concern, but there is no ready measure of their precise effect.

ACCOMMODATION

Two areas of concern to the Nursing Education administration and one to the Post-Graduate Medical Education Administration appear to be prominent. First, all the books for nurse training are stored in what was the demonstration room (now converted into a library/audio-visual room) and the librarian operates a personal requisition system, often sending books to the appropriate wards. Consequently, no central reading or study facilities are available to the nurses.

The other problem on that side is the sizing of the tutorial and practical rooms where only limited numbers can use them at any one time. In particular the practical room should have been designed like part of a ward or department, and the fittings and fixtures originally provided proved totally inappropriate.

The post-graduate facilities are mainly lacking due to the deficiencies of the existing lecture theatre, but also part of their seminar space has had to be acquired for the part-time nurse-tutors because of the conversion of most ward seminars to consultants' offices. Special requirements for patient-demonstration and for adequate film-viewing or lecture presentation have not been adequately met in this lecture theatre.

ENVIRONMENT AND ENGINEERING

Particularly the lecture theatre is causing irritation, which may be due to poor sight-lines, excessive heat and poor ventilation and insufficient width to accommodate a raked floor with through circulation to the corridors at either end.

The demonstration and practical rooms in the nurses education area have problems of poor daylighting, bad artificial lighting, no cross ventilation and circulation problems due to the placing of structural columns.

Other

One serious but now declining problem in this Centre has been security of books and personal items. The locking up of one end of the Centre at night appears to have contributed to the problem's decline. Staff and student 'education' in its broadest sense seems to have helped to some degree also.

EDUCATION AND TRAINING — CONCLUSIONS

Whilst the policy of multiple use and sharing of facilities seems to have worked in one hospital, it is obvious that it is not satisfactory to the other.

The design of the facilities can only be said to be partially successful, in that some of the coffee lounges and seminar/tutorial rooms are reasonable environmentally and in size, as is the library.

The unsatisfactory rooms, ie lecture room, multi-purpose seminar room (the one divided by a folding screen), the demonstration room and the practical room, are not well placed in the structure for ameliorating alterations to be made and do not provide acceptable working environments as they stand.

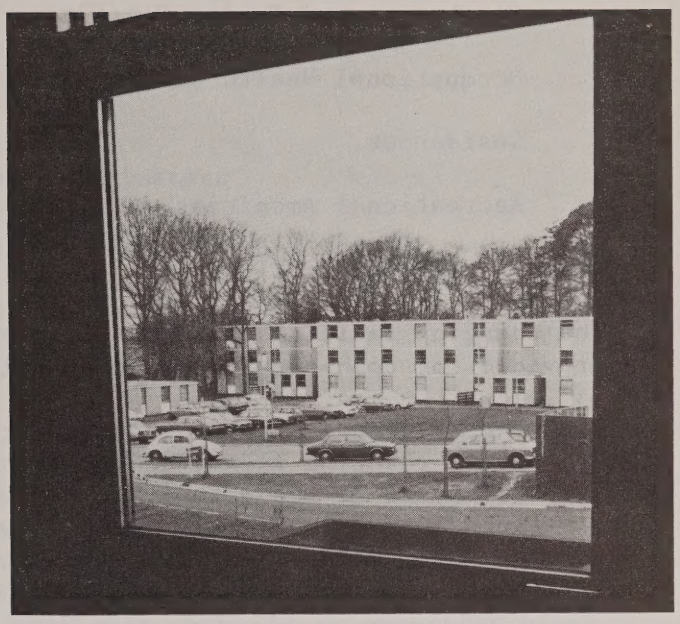
As there are moves by one group or the other to find adequate alternative accommodation - perhaps outside the existing peripheral departments - it is tempting to suggest that the Education Centre as such should be resited, and that the take-up of its present space should be most carefully analysed in order that other department do not fall prey to the functional and environmental draw-backs.

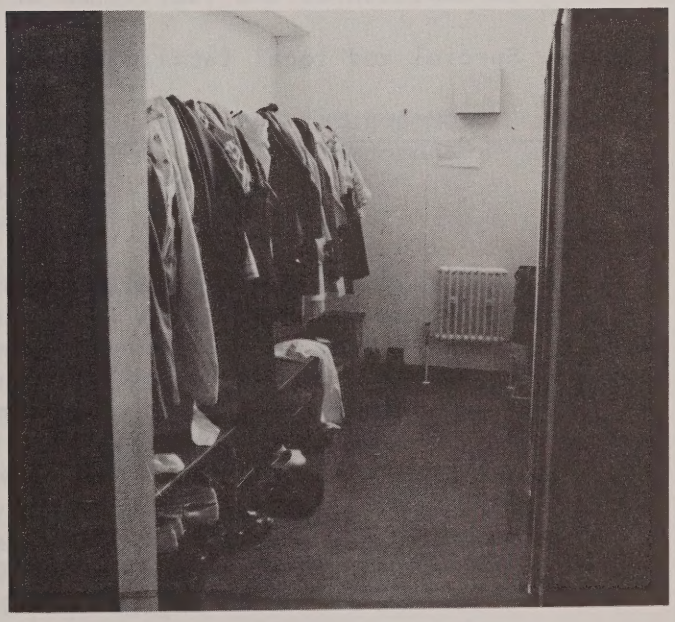
There have been nurse training and post-graduate medical training changes nationally which have radically altered the organisational and functional requirements for an Education Centre. Some of these could hardly have been foreseen at the time of the completion of the planning policies or when the plans were drawn up.

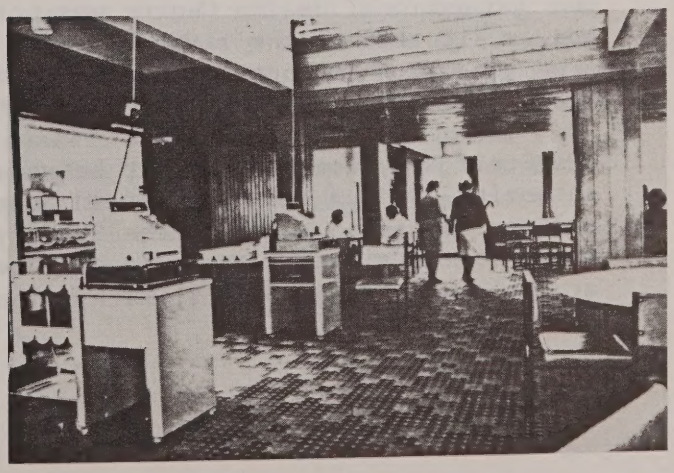
This points to careful consultation being held between users, designers and DHSS so that further changes could be met in any new accommodation that is provided, particularly as regards the number of offices.

Further studies are necessary and reference should be made to the reports produced by both hospitals and the investigations made by Dr Hind - 'Best Buy Evaluation Reference Group' DHSS.

Staff Facilities.







STAFF FACILITIES

This section includes:

Changing Rooms

Cloakrooms and Toilet Facilities

Occupational Health Centre

Residences

Recreational Amenities

LOCATION AND DESCRIPTION

The changing facilities (in most cases supplemented by toilet accommodation) provided for both hospitals can be split into 4 categories;

1 The main changing area containing non-resident nursing (male and female) staff changing rooms, and a clothing store, was 'centralised' around a courtyard in the ground floor Administration area because of space economies and supervision difficulties at ward/departmental level. A staffed 'exchange-basket' system for female staff and individual lockers for males was intended to apply.

2 Staff resident on site would be expected to use their own accommodation in addition to the facilities at ward/departmental level. (See later).

3 Special and local facilities are available in the following areas:

Operating Theatres	(special changing procedures)
Abnormal delivery	(appropriate clean/dirty and SCBU procedures to be decided locally)
ITU	
Physical Medicine	(staff and patient changing)
Isolation Unit	(infection control procedures involved)
Mortuary	(self-contained)
General wards and departments	(these are normally situated at the link entrance to a whole section)
Childrens and ENT Wards, OPD, A & E	(near the 'street entrance')

4 At both hospitals it was found necessary to include an extension to non-resident staff changing areas. This is of considerable size and is sited to the left of the hospital parallel to, and linked to,the Administration area at ground floor level.

The Occupational Health Centre was originally designated as a group health clinic and is situated on the first floor in the central block, next to but independent from the ITU. It contains a consulting/ examination room, 3 bedrooms, waiting and office space and a supplies and utilities area.

The Staff Residences are split between a number of on-sited residences and local authority housing nearby (and in Bury's case, use is being made of nurses homes and residences at and near the St Mary's site). At Bury, the residences are sited to the right of the main entrance and car park; at Frimley they are sited at the rear of the hospital site. There are three types of provision:

A = single bed/sitting room, sharing utility and common rooms

C = a suite of bedroom and sitting room, sharing utility rooms with another suite

D = self-contained flat: bedroom, sitting room, utility rooms.

They are provided in combinations in 3-storey blocks.

X = 3 groups of 4 clustered A's

Y = 1 group of 4 clustered A's and 2 D-clusters

Z = a cluster of 2 C's and 2 D's

In total, the accommodation provided was:

120	single study-bedrooms	(A)
6	bed-living room suites	(C)
12	single bedroom self contained flats	(D)

In Bury, the planned recreational amenities for staff consisted of a small common-room, linen/laundry/ironing and changing rooms sited underneath the gymnasium. In Frimley, more funds were available to build an amenities block near the residences; this additionally houses a bar and a large games/activity/ common room.

STAFF FACILITIES — BURY ST EDMUNDS

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

The policy of basket-change linen/uniform service does not apply and in fact staff uniforms arriving every day in bulk from Laundry are sorted by linen room staff and placed in numbered personal lockers. Deliveries are made separately to X-ray, Pathology, OPD and Accident and Emergency, and linen is delivered direct to the residences. The doctors appear to use departmental changing facilities rather than the central staff changing areas.

The Occupational Health Centre is run by a consultant physician and a full time nursing officer aided by 3 part time staff nurses. As a unit it was one of the first in the country and its operation seems to benefit from the communication links achieved by the consultant within the administration bodies of the hospital.

All staff are made aware of its services during induction and a screening test and medical service is provided for everyone. Staff may also come to consult on personal problems although, as with medical complaints, the person is generally referred to his/her local general practitioner. Links with the general practitioners are good and problems can be discussed, co-ordinated and treated (if necessary) in the patient wards. The unit does not act as an in-patient unit and has never been functionally or economically viable for night-time care (this is much better done on the wards). Staff admitted as in-patients in the hospital are admitted under the physician who happens to be on duty and the

Occupational Health staff will contact them to help where necessary and to maintain their own set of comprehensive detailed staff medical records.

The residences and recreational facilities on-site have proved essential additions to those sited elsewhere in the community. However, there is still a need for more staff (the whole spectrum) to be sited on-site and long-term plans are being made to at least duplicate the existing facilities.

ACCOMMODATION

The changing accommodation for non-resident staff was inadequate as estimated in the planning policies and a new block has already been provided (see previous notes).

The accommodation for changing in the Operating Theatres has been described as a 'slum'. Upon observation it was obvious that not only were the locker types completely the wrong shape and size but that the whole area was inadequate for circulation, for the hanging up of 'outside' clothes, for the delineation and racking of 'clean' shoes, gowns, masks etc. and for any space to sit and change. (Refer also to 'Environment'below).

As the Occupational Health Centre has never been used for sick staff overnight-stay, the bedrooms are used very flexibly for resting, testing, examining and carrying out very minor procedures or treatment. There have been more problems with placing telephones and lighting in the right place than any space problems. The storage area is stocked for the procedures carried out and the waiting area is a useful facility for informal discussions. (For further comments - see 'Environment' below).

Residences seem to be of the right mix of types but there is a need for more on site.

The amenities for staff are meagre and external playing space (games) had to be omitted. This provision will be upgraded in the long-term development of the site.

ENVIRONMENT

The two areas which caused comment were the Operating Theatres changing rooms where ventilation and cleaning problems were such that the 'place stinks'. This is serious and a proper study should investigate the problems to rectify the whole function of that area.

In the Occupational Health Centre, the internal office and consulting room tended to become stuffy; they occasionally suffered the efects of poor orientation of the clerestory lights and confidential conversations were very difficult to hold because of the poor sound attenuating properties of the structure and fabric. Other rooms were entirely satisfactory.

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

Uniforms are delivered to the linen room on site once a week wrapped separately in returnable polythene wrappers. They are sent either to the residences or to the changing rooms where they are identified for placing in individual numbered lockers. Separate deliveries of uniforms are made to the Pathology and X-ray departments.

The Occupational Health Centre is run by a senior nursing officer aided by 2 part-time sisters. A doctor/consultant is available 3 mornings a week. The Centre provides a District Service - undertaking perhaps 3000 staff treatments a year - but it does not provide overnight nursing care. Staff needing detailed medical attention are referred directly to their own general practitioner or, if necessary, to the Accident and Emergency Department; so there is no direct link to in-patient beds.

The District Management team inform all hospital staff of the service and treatment or advice is given on request. Because of the extensive District coverage the staff feel that it would be more appropriate to site the facility outside the District General Hospital (perhaps at some community health facility). Medical records (of staff who have attended) are kept within the unit, but there is no secretarial staff allocation to help organise this aspect.

The residences and staff amenity/recreational block are sited in good relation to the rest of the hospital. There is an urgent need, however, to house more junior medical staff in the locality - as near as possible to the hospital - and the difficulties of acquisition of suitable land nearby is causing concern to the hospital and to the District Management Team.

ACCOMMODATION

Further accommodation for non-resident staff changing (as at Bury) had to be provided as the total need - particularly for housekeeping staff - was insufficiently estimated.

Space provision in the Occupational Health Centre has been more than adequate and the use of the rooms has been flexible enough to enable examinations and a small proportion of treatments to be carried out. The storage space for supplies is not used.

The residences seem to provide adequate space/dwelling but it is felt that the mix of types is out of balance with Frimley's particular need for more accommodation for junior medical staff and married doctors.

Nursing accommodation would have proved a problem if adjacent facilities had not been negotiated with the local authority. It is envisaged that more nursing accommodation will be developed off-site.

ENVIRONMENT

The only particular problems mentioned at Frimley directly related to the facilities in question, were that the lighting conditions in the internal offices in the Occupational Health Centre were poor, and that the ventilation in the Operating theatre changing rooms was insufficient.

However, the staff in the Occupational Health Centre pointed to two particular areas of concern over health and perhaps safety, generally. They were firstly the collecting of trolleys outside Catering and the lack of proper disposal facilities within that department. This was suspected of giving rise to an 'unusual' incidence of illness (although this could be due to other factors such as ventilation and siting over Pathology or staff-training and work habits).

The other problem causing concern was the siting of the incinerator at the back of the hospital. 'It is invariably unclean, filthy, ... appalling'. The problems may have been exacerbated by the increasing use of plastic waste which produces a very high output of smut and grit.

STAFF FACILITIES

In general the facilities provided for staff, although a little 'meagre' (particularly in Bury's case) appear to have fulfilled their funcions well and have justified their attention in the Planning Policies. However, the Policies failed to foresee the impact of development and extension of the hospitals, and the increase in staff required in all departments to cope with the catchment area demands. Consequently changing and residential facilities in particular were seriously under-provided.

The Policy drawn up for the Occupational Health Service seems to have misinterpreted it is one for which a sick bay was necessary. Neither hospital unit has implemented this, but in actual fact both function in the capacity of a daily occupational health centre. No overnight nursing arrangements take place, as staff are referred either to their general practitioner or to in-patient care.

The advantages of having a consultant physician responsible at Bury have proved very effective in co-ordinating health care with necessary treatment, and in communicating with community general practitioners and with all hospital staff and administration.

CONCLUSIONS

General Amenities.

GENERAL AMENITIES

This section includes:

- Chapel
- Bank
- Shop
- Relatives Overnight Accommodation
- Patients' Library Service

LOCATION AND DESCRIPTION

The Chapel, Bank and Shop are all sited very close to each other between the end of the main entrance/snack-bar concourse and the hospital street leading to Administration. They are situated centrally to the major circulation of the hospital. The chapel consists of one main and two subsidiary rooms.

Relatives Overnight Accommodation may be variously allocated in ordinary single ward rooms around the hospital (if available and only when absolutely necessary). More specific provision is made in the end 2 rooms of the Day and Emergency Suite and in the adjoining 'link' corridor.

The patients' library service would use a store in the Education Centre, but would consist of trolleys taken to wards by hospital volunteer workers.

PURPOSE, FUNCTION AND ADMINISTRATION

Although patient reception is covered more formally in 'Patient Services' it is appropriate here to state the intentions of the planning teams in providing information services and gaining feedback from the local community. It was intended that a descriptive booklet describing the hospital services and facilities would be available not only to prospective patients, but also to community GP's and perhaps even to other staff - the latter particularly needing to know about the 'Occupational Health Service'.

It was also intended that suitable forms be made available to patients in order that they might record their response to service and the environment if they so desired (thus providing a partial view from the other side).

The Chapel was to be for multi-denominational Christian worship and meditation and the two ancillary rooms would be designated as vestry and interviewroom/oratory. Chaplains and ministers would contribute to patient welfare on the wards but 'formal' functions of their appointment would take place in the Chapel or where necessary in the Mortuary.

Both the Shop and the Bank were intended to be leased as virtually self-contained concerns, the former possibly being run by voluntary services. Arrangements for opening hours, cleaning, storage and supplies would be the responsibility of each, although the shop service might come to a working arrangement with Central Stores for bulk deliveries. A ward-trolley service would be provided to take goods from the shop to bed-fast patients.

Relatives overnight accommodation and the patients' library service have already been described.

PURPOSE, FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

The Bank, which is independently run by the appropriate company, and other facilities have been put into operation effectively and to all appearances to the patients' satisfaction. The Bank is open every day at prescribed hours, the Shop run by the WRVS is open for a substantial period of time every day and the Chapel is permanently open.

ACCOMMODATION

Whilst the Bank and Shop appear to be much appreciated by staff, patients and visitors, the particular problems encountered by both are lack of secure cash-checking space and in the latter case insufficient room for storage of bulk supplies also. It doesn't appear that the Supplies Centre makes provision for the shop storage requirements. The other point is that these facilites are located in a very tight circulation area near the main staircase and the main hospital street, as a result queues tend to form and partially block the throughway of other people.

The Chapel is sufficient in size and its central position is of course very convenient. During the course of the evaluation it didn't appear to be very much used and alterations were taking place to reduce the 'austerity' of the layout, by removing the formal double-'U fixed seating, and installing a looser assembly of chairs.

ENVIRONMENT AND ENGINEERING

From the patients' point of view, one problem was more prominent than any others. This was the insufficient or confusing signposting and the lack of a strong sense of direction in the hospital. It was pointed out that being a less urbanised population, local people coming to hospital in a state of concern or stress would not be as familiar at direction-finding as say a daily commuter on the London Underground. The problems seemed to reduce at the incidence of a second visit or after familiarisation.

Other environmental comments generally appear to substantiate the view that the hospital is well-liked by the local populace (see in particular 'Landscaping and Courtyards' in Appendix 1).

GENERAL AMENITIES FRIMLEY

PURPOSE,FUNCTION, ADMINISTRATION, WORKLOAD AND STAFFING

The Bank is run by the appropriate company opening one or perhaps two days a week. Other banking facilities are located in Frimley town centre itself (½ mile or 2/3 kilometre away). The Shop is run by WRVS in close co-operation with the Voluntary Services organiser and is open for regular periods every weekday. The patients' library trolley service is also organised by volunteers. An additional feature at Frimley is the daily broadcasting service - located centrally in the Education Centre - which is entirely manned by about 50 volunteer workers.

ACCOMMODATION

The only obvious problem is the location of the Bank and the lack of space where money can be counted and checked. This problem is also experienced by the shop staff. A new 'strong room' area is being made in the Administration area and it has been suggested that the Bank could have been sited adjacent. The provisions of the Chapel appear to be satisfactory, and there is ample room for books for the patients' library service.

Little comment was made on overnight stay rooms for relatives, but it is possible that with the pressure on bed-space being what it is in Frimley, the ability to allocate overnight places 'liberally' around the hospital could not occur. Junior doctors on call are short of accommodation on site, and quite often need to use the overnight rooms.

ENVIRONMENT

The only particular comments from staff and patients appropriate here are the difficulties of finding an exit once the person has travelled any distance in the hospital, and the general comments about overheating and poor ventilation locally (refer to Engineering.)

GENERAL AMENITIES — CONCLUSION

The policy of providing general amenities was orientated most specifically towards the patient, and as such appears to have worked very well.

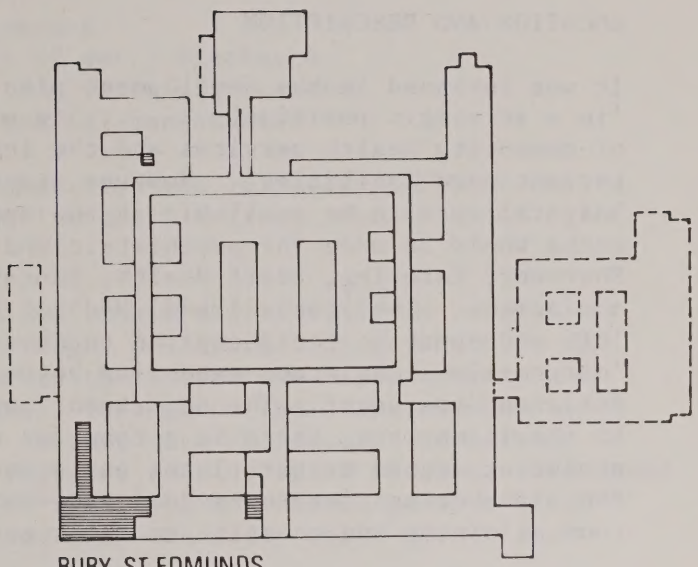
Within the hospital there are still problems of direction finding and the need for easy access to information and help - particularly for visitors.

Both hospitals have coped with this in different ways. At Bury,the co-ordinator for Voluntary Services has her office very near the main entrace and is readily accessible for enquiries. Quite often a volunteer or a porter will help with enquiries in the main entrance. At Frimley, a desk manned by three volunteers has been set up to the right of the main entrance in what was a wheelchair bay, and the volunteers provide an excellent service in guiding all hospital users in their need for amenities and service. (A desk has also been set up to enable fund raising to take place in the main snack-bar concourse - collecting for a hydrotherapy pool.)

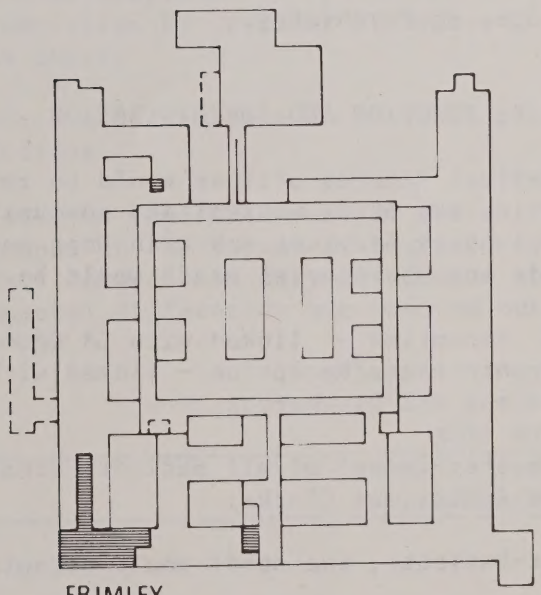
The main entrance reception desk at both hospitals is not staffed 24 hours/day and was never really operated as a complete reception facility, functioning mainly for outpatients appointments. As such it leaves a gap in not being able, automatically, to direct visitors to patients on the wards, and it occupies too vital a site for such partial functioning. At night it is not staffed at all and although all public access and departure to the hospital should be through Accident and Emergency, inevitably people needing information and direction congregate in the daytime snack-bar/entrance concourse and have no direct information source to turn to.

As has already been stated, the general amenities were provided on the patients behalf. They have also proved popular with staff (comments and observation prove this). Bearing in mind the fact that at both locations staff needing such facilities during their working day could hardly reach external/community amenities in their lunch or coffee breaks, it is a great pity that a few more facilities were not generally available. (Refer to 'Staff Facilities').

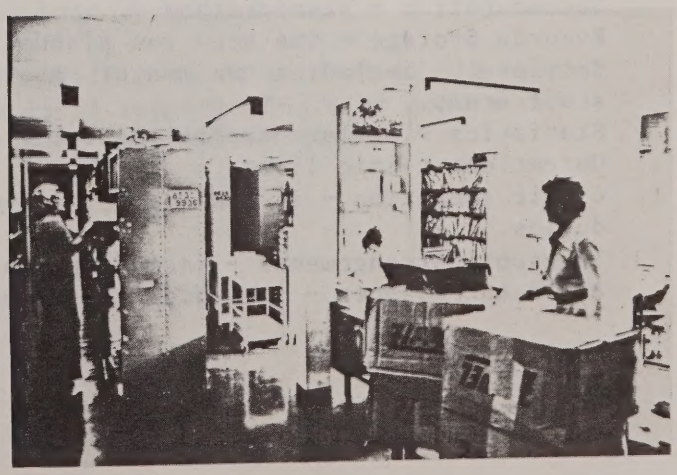
Patient Services.



BURY ST EDMUNDS



FRIMLEY



PATIENT SERVICES

This section includes:

Medical Records
Patient Reception - Admission, Discharge etc
Medical Secretaries

LOCATION AND DESCRIPTION

It was intended in the development plan to site the Medical Records department 'in a strategic position' ..... 'to play an important part in the co-ordination of community health services and the intensive use of all the hospitals's patient care facilities'. However, current records of patients attending the hospital were to be available at the appropriate department and special arrangements would be made for psychiatric and geriatric day patients, for Stores and Pharmacy, Catering, Staff Health, Education, X-Ray and also for Maternity admissions. The 'centralised' Medical Records department is located to the left and opposite the reception counter of Accident and Emergency with a 'diagnostic-index' room extending between consultants offices in the Administration department. The department contains an 'active' and a 'dormant' side to the files area, there is a room for medical secretaries, a machine room for producing record master plates and other indexing accessories, and in addition the alphabetical 'master-index' and admissions registers are maintained in a room adjoining and en-suite to the reception counter in the Main Entrance.

The room allocated for the central 'pool' of secretaries is designed to accommodate up to 10 people, however, for consultants whose offices are some distance from the Administration block it was intended to provide secretarial accommodation en-suite, eg Psychiatry.

PURPOSE, FUNCTION AND ADMINISTRATION

The Medical Records officer would be responsible for vital links with Local Authority and other medical and community services working in liaison with Social and Voluntary Services and with Unit and District administration. The medical records and secretarial staff would be principally concerned with:

A & E Reception - linked with LA Communications
OPD Appointments/Reception - linked with Specialist Clinic and Day Centres
Admissions and Discharges

The 'master-index' of all patients treated in the hospital would be maintained by the Admissions Clerks.

In Out-Patients, the staff would organise:

Clinic appointments
Documentation - standardised
Records Storage - the area was planned to take 6 years minimum
Retrieval - including the use of 'master' and 'diagnostic' indices for medical staff study
Statistics - eg for Hospital Activity Analysis (HAA)
Outpatient clinic lists
Clinic reception - in sub reception areas to relieve nursing staff of non-nursing duties.
Transport arrangements - including liaison with ambulance authorities
A & E attendances - including the issue of separate 'transitory' records.

For In-patients, medical records procedures would cover:

Waiting Lists - maintenance of register
Day Surgery - particular links with Central Treatment Suite and Day and Emergency programmes
Day Centres - sub reception/records offices
Admissions - upon arrival or the following morning after night (D & E) admission
Psychiatric and Maternity admissions
Births and Deaths - all statutory requirements
Discharges - monitoring the effectiveness of early discharge
Case-notes - retrieval of records/notes from wards/clinics etc
Clinical Data - upkeep organised by the medical secretaries

Transport - liaison between ambulance authorities and voluntary car services is the special responsibility of the Transport Officer, who is aided by the portering staff.

Although all records are held and maintained within the centralised records department ultimately, special procedures might be adopted for psychiatric and maternity admissions which are controlled in the respective departments. The same goes for a number of 'Isolation' cases. Throughout the hospital, the ward/departmental staff should maintain daily contact with the records department and it was intended that the daily ward-register entries would be cross-referenced with records except where the incidence of treatment and discharge on a 'casual' (and not further connected) basis occurred, when the entry would remain the only record.

Upon patient discharge, the co-ordination of community services remains a vital part of the medical records service and notes completed by medical staff would pass back to the admissions office for completion by procedures, before going via the 'diagnostic index' to the records store.

The medical records establishment was intended to comprise 26 clerical officers, 10 clerk/typists and a 'pool' of 9 secretaries.

NOTE: Because this department should really be read as a service the notes and information here are only loosely grouped in the format of the report, and are made in a more truly comparative form. Comments on Bury St Edmunds and Frimley are grouped together, only fundamental differences are pointed out.

PATIENT SERVICES — BURY ST EDMUNDS

FRIMLEY

FUNCTION, ADMINISTRATION AND STAFFING

The policies have not been found satisfactory because there is too much fragmentation with too many outposts (some of which have been abandoned).

Workflows are difficult and an increase in staff numbers is needed. In both hospitals it was strongly felt that the medical records should be centralised in the main Accident and Emergency department, near the entrance.

Staffing:

The original levels were considered too low and extra staff were also needed for the important first 6 months after the commissioning of the department.

There are approximately 65 staff, including a large number of married women (some working for 'pocket money' it is said).
There are staff in the following departments:

Psychiatry
Operating Theatres
Central Treatment
Geriatrics
Rehabilitation
OPD
Main entrance
Accident and Emergency
Central (main) Records
Secretaries (dispersed)

Because of the enormously widespread distribution of staff, effective control has been found very difficult.

There are some problems with the messenger service, and at Bury housekeepers take all messages.

ACCOMMODATION AND ENVIRONMENT

At Bury St Edmunds this has been found to be totally wrong, with the wrong type of rooms and insufficient shelving. Particularly the mobile stack shelving is not liked by some staff who are both afraid of it and find it wasteful of time. Static racking has now been installed.

Medical Secretaries Room:

This has been found too large to suit its purpose and is poorly fitted - particularly electrical sockets are in the wrong places.

OPD:

There appear to be too many 'hiding places' for patients and this results in difficulties with record storage and security.

Master-index:

This is in the wrong place and should have been the focus of centralisation of the department.

There are some 250,000 case-notes, and 14,000 new case-notes are being created each year. As a result the department will be changing over to using microfilm.

Security:

This is difficult in the main department as elsewhere, partly because the department is used as a through-route or corridor. There is a high rate of theft.

At Frimley, acccommodation has been lacking for medical secretaries. Consultants are not using the consultants rooms and have instead taken over the seminar-rooms on the wards. All other accommodation comments are similar to those for Bury.

Racking:

The mobile racking is sufficient only for 6 years records and the 'Congenital Deformities Act' now demands the retention of medical records for a minimum of 21 years. This is going to cause considerable storage problems. Additionally, the racking is heavy to move and needs power assistance.

PATIENT SERVICES — CONCLUSIONS

The notes made here are not detailed and further detailed studies must be carried out on the design of the departments, and in particular on the systems of storage, recall and duplication of records. Some notes are included in the section on other departments (where appropriate).

In particular the 'Congenital Deformities Act' will now make a considerable impact on the department and its ability to accommodate development and change. Records have now got to be stored for between 21 and 25 years. Microfilming may solve the problem (aided possibly by computers), but other equipment will need to be brought in to reproduce documents etc.

Reorganisation of the National Health Service has affected the ability of the department to contact and help people at the right levels and to get decisions made.

The planning policies did not fully anticipate the effect of the catchment areas' enlarging; in Bury's case, geographically, in Frimley's, by population expansion.

In both hospitals the design of the department has appeared to leave much to be desired. A lot of the problems are managerial and organisational in nature, but the planning of the department has resulted in obvious fragmentation of the workload and workforce and in the uncertain problems of duplication and distribution of the records themselves.

Housekeeping.

HOUSEKEEPING

This section includes:

1 Maintenance of an acceptable standard of cleanliness throughout the hospital.

2 Domestic cleaning aspects of control of infection.

3 Housekeeping support (including clerical work, patient-orientated tasks, ancillary and communication work) for the nursing and catering services.

For upkeep, maintenance and repair of building fabric, fittings, furniture, services and engineering plant refer to: ENGINEERING, WORKS, MAINTENANCE AND DISPOSAL.

For education and in-service training refer to: EDUCATION AND TRAINING.

LOCATION AND DESCRIPTION

The term 'housekeeping' refers to a whole-hospital service rather that a department, however, it is organised from a number of offices. Three offices for the administrative and managerial control are situated in the ground floor link-corridor to Administration. Elsewhere in the hospital one housekeeper's office/reception area is provided in the link-corridor between 2 wards (ie one office/72 beds).

PURPOSE, FUNCTION AND ADMINISTRATION

The purpose and function of a fully-integrated housekeeping service is to 'relieve nurses of non-nursing duties' thus enabling 'effective re-deployment of nursing skills', as part of a major policy involving the 'co-ordination, liaison, planning, organisation and budgetary control of cleaning services throughout the hospital'.

At ward and departmental level with little variation, it was intended that whilst the housekeepers would come under the 'domestic establishment' the sister would 'maintain full clinical control and would advise the assistant housekeeper on the organisation of work'.

Operating Theatres and TSSU would make special 'housekeeping' arrangements for all cleaning duties. Engineering and Works, Kitchens and dining/snack areas and the Mortuary would have their own organisations for cleaning.

Housekeeping Duties were to include:

1 Cleaning and Maintenance of equipment and fabric as appropriate at ward/department level and routine cleaning of beds.

2 Supply and Disposal of stock, stores, linen equipment, meals etc, and other items at ward/department level and communication with Administration, Supplies, Engineering, Maintenance and Portering staff, such that the latter's involvement and intrusion into the ward/department was kept at a minimum.

3 Catering - liaison with Catering department, and organisation in the wards and some departmental areas of distribution and collection of foods and beverages.

4 Administration and Records - including liaison with other departments, management and care of patient's effects, monitoring telephone calls, aiding in the admission and discharge of patients in liaison with Admissions Officer.

5 General Assistance - including stripping and making unoccupied beds, aiding, supporting and advising relatives or visitors as appropriate.

6 General Liaison with all hospital staff concerning cleanliness, control of infection and the maintenance, repair or replacement of all items within their area of jurisdiction needing attention.

This last point in particular will affect the meaning and elasticity of job-descriptions as the 'Health and Safety at Work Act' becomes fully operational.

HOUSEKEEPING BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

At Bury only a partial housekeeping service operates and the service has been divided as follows:

a) basic cleaning to all wards/departments and residences.

b) reception/clerical service to all wards (but not at all times).

c) full housekeeping in G2 (Geriatrics) and F5/6 and F7/8, the Surgical and Medical wards.

The lack of full housekeeping has been caused by initial difficulties in local recruitment 1974-75 and by the 'subsequent financial restrictions' and as a result whilst the preceeding activities are undertaken the availability of housekeeping staff in any area of the hospital remains variable and the duties often revert to the nursing staff, particularly during nights, weekends, holidays and sickness.

Because of this variability, certain confusion surrounds patient-orientated tasks and nursing staff often have to take records and do patient reception. Conversely basic grade housekeeping aides are often relied upon to help 'beyond their job terms of reference' during very busy periods.

The clerical work done by the section housekeepers seems to be much appreciated ('sister's right hand') but the geographical relationships of the housekeepers and records to the nurses station (from which sisters operate) appears to prevent much of the visual and audible communication desired between the two.

The nurses would prefer to reinstate the old style nursing-aides, cleaners and ward-clerks; the housekeepers would like to run a complete housekeeping service. The present most favourable option appears to be to intensify and broaden the education of housekeeping staff, and to educate the nurses in how to make best use of them, in jointly supervised team work. This would imply rationalising the housekeeping to two grades and increasing the establishment to provide a uniform service throughout the hospital.

WORKLOAD AND STAFFING

Despite the problem of organisation and management of the service, the housekeeping workload appears moderately satisfactory.

Overall supervision of services is undertaken by a District Domestic Supervisor The remaining structure (funded) is contrasted against a 'Full Service' complement (desired) and a DHSS recommended establishment:-

DHSS	FULL SERVICE	ACTUAL FUNDED	ESTABLISHMENT
1	1	1	District Supervisor
1	1	1	Domestic Services Manager (DGH)
2	2	2	Assistant Manager (ADS)
8	8	1	Senior Housekeeper
16	16	10	Housekeeping Supervisor
143	188	135	Housekeeper (including: Section Housekeepers and all grades)
1+1	1+1	1	Linen Supervisor and Assistant

Further staff (figures not clear) have been added to service the Geriatric and other extensions. As can be seen, the actual funded establishment meets neither "full" nor DHSS recommended levels.

ACCOMMODATION

The policies stated that the housekeeping rooms in each link-corridor were to provide shared accommodation for section and supervising housekeepers. This has never materialised and the space is very small and too far removed from the nurses stations to be of value in housekeeper/nurse communications. Coupled with other problems this contributes to the situation where nobody full-time is doing patient/visitor reception, monitoring records and communicating with all other hospital staff.

No accommodation at all was provided for senior housekeepers.

A linen room extension in the Supplies Block at the rear of the hospital has rectified a previous omission.

Storage of cleaners equipment appears to be satisfactory generally, but the actual ward storage and disposal areas are awkwardly shaped and are not sufficiently fitted-out to provide the flexibility of operations required. Only in one area does storage appear to be very inadequate - this is in the Central Treatment Suite where treatment room hatches to the corridors (lockable) are filled with CSSD and other supplies.

The biggest critical commentary concerned lack of ancillary space in the Operating Department, where shared disposal rooms are very small and difficult to clean, and where the staff changing area is so small and cramped as to appear 'slum-like' and presents serious cleaning and source of infection problems.

ENVIRONMENT/ENGINEERING

The responsibilities of housekeeping staff under the new 'Health and Safety' legislation concerning fabric and ward/departmental maintenance will continue to be put under pressure because of the variable cover of service provided.

As a consequence total hospital planned preventive maintenance remains an objective rather than an implementation.

The other problems mentioned were poor local ventilation in small offices and kitchens, and the low standard of wall-finishes and provision of special protection against knocking, splashing etc. (See References for special Studies).

Floors in Operating Theatres are cracking and causing concern.

Floor colouring generally is 'dull' and 'inappropriately white' around the busy nurses stations.

Trough urinals are not being used due to staff union objections.

Courtyards, though appreciated, cause irritation to the housekeeping staff due to the ingress of dirt, grass etc in the hospital streets.

HOUSEKEEPING FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

At Frimley, despite a 10% reduction on estimated establishment requirements, a full housekeeping service is provided. Level of service varies according to need and the hospital has been divided as follows:

a)	in-patient areas	= wards, ancillary spaces, offices.
b)	day/out-patient areas	= wards/departments
c)	special areas	= Operating Theatres, ITU, Isolation etc
d)	administration	= non-ward offices, corridors, staff areas.

in (a) full housekeeping is provided from the first to the last patient meal every day of the year. A night time service is not available, but a small housekeeping team is always on call if required, and they also undertake cleaning and disinfecting of machinery and equipment.

In (b) the housekeepers are present during and briefly after use, to aid procedures, and ensure cleanliness.

In (c) special arrangements for timing and procedures have been made.

In (d) a housekeeping service is provided after working hours.

In Catering, Engineering and Works, Supplies and the Mortuary areas the appropriate heads of departments are responsible for cleaning organisation, however, the housekeeping staff do undertake basic cleaning of offices and lavatories in these areas.

The problems of communication between nurses and housekeeping staff are seen as being due to the physical separation of housekeepers offices in the link-corridors (this has been remedied in some instances by placing the housekeeping-receptionist directly between two 36-bed sections) and due also the the 'grey areas' of insufficient education about role-playing, where control of duties and standards of service are concerned.

Personalities in management at local ward/departmental level as well as administrative level inevitably cause some problems. Everyone concerned seems to be aware of this and communication and co-operation is being encouraged; in particular nursing officers are being involved in the recruitment and training of new housekeeping staff.

Two modifications of service at ward level do not follow the original policies: firstly the nurses rather than housekeepers undertake the ordering of all medical and surgical stores, and secondly owing to the fast throughput of patients it has been found too awkward to transport beds to the ground floor for cleaning, so they are cleaned on the wards.

WORKLOAD AND STAFFING

The nature of the workload was such that senior housekeepers were never required and office space for them didn't exist. The resulting establishment is therefore:

1	District Domestic Supervisor
1	Housekeeping Manager
3	Assistant Housekeeping Managers (1 responsible for residences) (1 responsible for all wards/departments under General Nursing Division) (1 responsible for midwifery, psychiatry, administration, education, records and equipment)
16.8	wte Housekeeping Supervisors
23.6	Housekeepers
142.2	Housekeepers (other grades)
1	Clerk
1	Linen Room Supervisor
1	Seamstress
5	Linen Room assistants
195.6	wte total establishment

The make-up of a housekeeping service on an average 36-bed ward would be:

1	housekeeper
1	deputy
2	assistants (1 part time)

ACCOMMODATION

As has been mentioned previously the lack of housekeeping offices in the right place for senior housekeeping staff has proved a problem, although local innovations on the wards have improved communications and function considerably.

No facilities for housekeeping accommodation at all were planned in SCBU, Operating Theatres, ITU, Central Treatment Suite, Day and Emergency department, Accident and Emergency, Outpatients Department and in the Ante-Natal Clinic. However, flexibility has led to use of existing accommodation and the situation appears to be satisfactory.

Storage space for housekeeping purposes throughout the hospital appears to be satisfactory.

ENVIRONMENT/ENGINEERING

The walls and floors have caused some dissatisfaction particularly due to inappropriate colouring, and in the case of the walls the difficulty in maintaining the surface whilst having to wash them down.

Particular notice should be taken of the problems of damage and suitability of materials and fabric (see Appendix 1 - 'Quality and Environment').

The other major problem has been the type of equipment provided for cleaning. This is gradually being remedied.

More areas in the hospital could have been carpeted including the circulation spaces in the residences.

The maintenance and cleaning of the hospital streets presents certain problems because they are always in fairly heavy use.

HOUSEKEEPING

CONCLUSION

In the Planning Policies it was decided to proceed with the 'fully-integrated' Housekeeping Service in the Bury and Frimley hospitals alone, where the 'experiment' should proceed to the point of a design-in-use evaluation.

To some extent this particular 'evaluation' has reached that point, but it is strongly recommended that the organisation of housekeeping at the two hospitals should be considered in relation to the reports and policies produced by each department , and in relation to the differing problems encountered by each hospital. The two hospitals' services are not strictly comparable and neither has essentially met the original policy of full-housekeeping.

After the policies were written, the establishments of staff at both hospitals were frozen, under different conditions, leaving Bury with essentially a domestic staff only and Frimley with a 10% depletion of its estimated staff requirement.

On top of this the catchment population has put unexpectedly heavy demands on the service at Frimley, whilst at Bury the service has been stretched by idiosyncratic movements and referrals of patients within the Region, and of course by the extensions of various departments.

Despite this the slightly overdetailed lists of appropriate non-nursing duties produced and adhered to by both departments (see Reference) almost duplicate each other and fulfil all the requirements laid out in the original Planning Policies.

There are considerable grievances about the degrees of success of 'integration' of this new organisation (housekeeping). The biggest problem from both nursing and housekeeping points of view is the problem of communication and co-operation at ward/department level as to who does what, and the hazy duplication of management, which the policies never explained.

In addition to this, certain problems of personality conflict are tending to occur because the link through nursing, between the way the ward/department is domestically organised and the manner in which the medical/consultant staff wish to co-operate, is not one of direct control by the sister concerned.

It should be pointed out that in several instances the co-operative 'team-work' between nursing and housekeeping staff has flourished and some of this appears to be due partly to re-siting supervisors or section-housekeepers nearer to the nurses stations. But this success is also due to the re-interpretation of the job outlines resulting in a flexible organisation that can cope with such problems as absenteeism, sickness, unbalanced workloads and emergencies.

Where there have not been sufficient housekeeping staff to provide a full service, arrangements have had to be made for either a partical service, or in fact some of the workload has passed back to the nurses. At Bury St Edmunds this situation has affected particularly the whole of the Obstetric Department.

The problems here have been seen as making extensive time demands on the supervisor/section-housekeeper's duties so that up to 70% of their time is spent doing clerical work. This has tended to leave two grades of staff attempting to fulfil the normal duties of three grades. (ie the housekeepers will also cope with some admission and discharge work as well as doing patient-orientated tasks, and the cleaning-aides will often be called to undertake patient-orientated tasks to help the nurses).

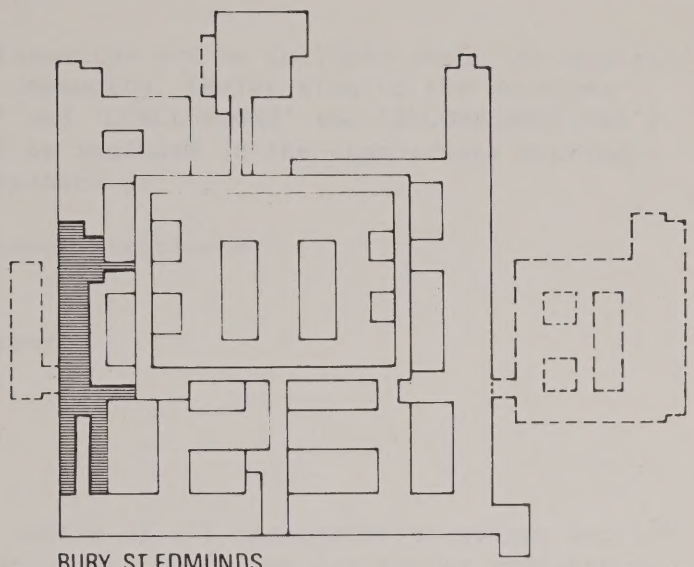
With a larger complement of staff at Frimley, the problem has to some extent been rationalised and a section-housekeeper now sits within certain ward areas and receives, directs and manages patients, visitors and her own staff, as well as being able to communicate much more directly with the nurses.

Efforts were made at the time of commissioning and during and after NHS reorganisation to parallel the Salmon nursing establishment with appropriate housekeeping staff. Both hospitals complain that the appropriate links do not exist and possibly the reason is that for convenience and streamlining the housekeeping management has attempted to split responsibilities rather more on the basis of the divisional work loads (but only instituted in the one hospital).

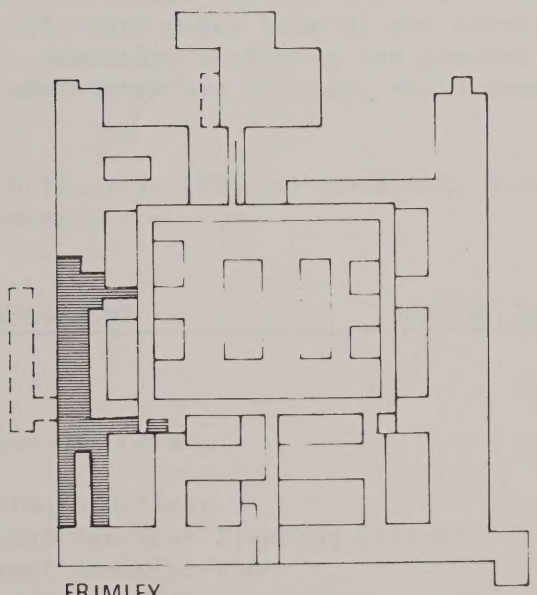
With one exception there are no senior housekeepers who could match the SNO establishment and the numbers and duties of the housekeeper supervisors differ radically from the SNO structure. This also applies at ward/departmental level where the section housekeeping service is at variance with the nursing structure.

One final point is that the facilities for all staff within the hospital (except changing facilities) are minimal, and there is a pressing need for heads, supervisors and others in the staffing hierarchy to be able to mix and meet each other. This cannot be undertaken either in the Education Centre or in the Conference Room because of the heavy booked use of these areas. The provision of appropriate spaces centrally within the hospital might have helped enormously (refer to 'Administration' and 'Conclusions').

Administration.



BURY ST EDMUNDS



FRIMLEY

ADMINISTRATION

Administration and management affect anyone connected with day-to-day or long-term involvement with the hospital. The object of this administration and management is to support a service of health care for an extended, complex community. It was beyond the parameters of this study to measure the effect of Best-Buy hospital planning, its administration and management, as seen from the patient/recipient's point of view.

Furthermore, only brief and general information can be included about administration and management in relation to the community. (Refer also to the sections on 'BACKGROUND AND GENERAL INFORMATION' and 'CONCLUSIONS' and 'RECOMMENDATIONS'). Details at ward/departmental level will be included in the appropriate section. This section provides an outline and feedback on :

General Administrative Management Structures
Medical Administration
Nursing Administration
General - Portering and Transport
- Voluntary Services
Social Services

LOCATION AND DESCRIPTION

The hospitals were designed to 'be the centre of all management committee activities, and to enable these to be integrated with their own day-to-day administration'.

Departmental administration is mainly decentralised but the Administration block, situated on the ground floor on left-hand outer side of the hospital, contains a group of consultants offices, domestic, portering and general administrative offices, senior nursing administrators offices, and a committee room.

The social work staff were allocated 3 offices in OPD, one in A & E, one in the Psychiatric unit, and two more elsewhere.

REGIONAL AND AREA ADMINISTRATION AND MANAGEMENT — BURY ST EDMUNDS

EAST ANGLIAN REGIONAL HEALTH AUTHORITY

Regional Team:

Administrator
Treasurer
Medical Officer
Nursing Officer
Works Officer

General Services:

Blood Transfusion Service
Regional Nurse Training Committee

Senior Officers:

Ambulance Officer
Capital/Services Planning Officer
General Administrator
Information Officer
Management Services Officer
Personnel Officer
Supplies Officer
Principal Assistant Treasurer
Specialists in Community Medicine (4)
Pharmaceutical Officer
Scientific Officer
Nurses - Personnel/Education
Capital/Services Planning
Architect
Engineer
Quantity Surveyor

AREA HEALTH AUTHORITIES AND DISTRICTS

Cambridge AHA (Teaching)
Cambridge HD (Teaching)
Peterborough HD

Norfolk AHA

Norwich HD
Great Yarmouth and Waveney HD
Kings Lynn HD

Suffolk AHA

Ipswich HD
*Bury St Edmunds HD

AREA : DISTRICT : DGH ADMINISTRATION AND MANAGEMENT — BURY ST EDMUNDS

Suffolk AHA (Ipswich)

Area Team:

Administrator
Treasurer
Medical Officer
Nursing Officer

Senior Staff:

Administrator Family Practitioner Services
Chief Ambulance Officer
General Administrator
Personnel Officer
Supplies Officer
Senior Assistant Treasurer
Specialists in Community Medicine
- Child Health
- Social Services
Dental Officer
Pharmaceutical Officer
Area Nurses - Child Health
- Personnel/Planning
Works Officer
Building Officer
Engineering

BURY ST EDMUNDS HEALTH DISTRICT

District Management Team:

Administrator
Finance Officer
Community Physician
Nursing Officer
Consultant
General Practitioner

Senior Officers:

Administration) General Administration
Support Services)
Domestic Services Manager
Personnel Officer
Pharmaceutical Officer
Works Officer
Building Officer

General Services:

Offices for Community Health Services
Nurse Training School
Community Health Council

DGH Management:

Unit Administrator
Hospital Engineer
Unit Domestic Manager
Operational Services Officer
Linen Services Manager
CSSD Manager (District)
Senior Supplies Manager(District)
Assistant Unit Administrator (Transport)
District Catering Manager & Unit Manager
Divisional Nursing Officer (2)
Director Nursing Education
SNOs (5)
Medical Staff Committee
District Medical Records Officer

REGIONAL AND AREA ADMINISTRATION AND MANAGEMENT FRIMLEY

SOUTH-WEST THAMES REGIONAL HEALTH AUTHORITY

Regional Team:

Administrator
Treasurer
Medical Officer
Nursing Officer
Works Officer

General Services:

Blood Transfusion Service
Mass Miniature Radiography
Regional Computer Centre
Regional Education and Training Centre
Regional Nurse Training Committee
London Ambulance Service

Senior Officers:

Ambulance Officer
Capital Services
Catering Adviser
Domestic Services Adviser
General Administrator
Legal Adviser
Management Services Officer
Personnel Officer
Public Relations Officer
Supplies Officer
Principal Assistant Treasurers (2)
Specialists in Community Medicine (3)
Pharmacist
Scientific Officer
Nurses - Personnel and Management
Capital Planning
Professional Education & Training
Architect
Engineer
Quantity Surveyor

AREA HEALTH AUTHORITIES AND DISTRICTS

Surrey AHA:

*West Surrey/North East Hampshire HD
South-West Surrey HD
North-West Surrey HD
North Surrey HD
Mid Surrey HD
East Surrey HD

West Sussex AHA:

Chichester HD
Cuckfield and Crawley HD
Worthing HD

Croydon AHA:

Kingston and Richmond AHA:

Merton, Sutton and Wandsworth AHA (Teaching):

Roehampton HD
Wandsworth and East Merton HD (Teaching)
Sutton and West Merton HD

Surrey AHA (Guildford)

Area Team:

Administrator
Treasurer
Medical Officer
Nursing Officer

Senior Officers:

Administrator - Family Practitioner Services

Chief Ambulance Officer
General Administrator
Personnel Officer
Supplies Officer
Senior Assistant Treasurer
Specialists in Community Medicine :
- Child Health
Health Care Planning & Information Office
Social Services Officer
Dental Officer
Pharmaceutical Officer
Area Nurses - Personnel
- Child Health
- LA Liaison
- Service Planning
Works Officer
Building Officer
Engineer

West Surrey : N.E. Hampshire Health District

District Management Team:

Administrator
Finance Officer
Community Physician
Nursing Officer
Consultant
General Practitioner

Senior Officers:

Ass. District Admin - Operation Management
- Planning Personnel
- Management Services
Catering Manager
Domestic Services Manager
Dental Officer
Pharmaceutical Officer

General Services:

Offices for Community Health Services,
Salaries and Wages Office,
Frimley Park and Brookwood Hospitals Nurse Training School,
Community Health Council

DGH Management:

Sector Administrator (3)
Works Officer
Building Officer
Engineer
Domestic Manager
Catering Manager

Divisional N.O. (4)
Manager (District)
CSSD Manager (District)
Assistant Supplies Manager
Medical Staff Committee
Hospital Medical Executive Committee
Medical Centre Committee
General Practitioner Medical Staff Committee

PURPOSE, FUNCTION, ADMINISTRATION AND MANAGEMENT

Final details of Medical and Nursing establishments were not available in the Planning Policies. However, the following establishments were used as a guide to providing offices in OPD, in wards/departments, or in the central Administration block.

Medical Consultants: (whole time equivalents)

Medicine	6
Surgery	9
Obstetrics and Gynaecology	3
Anaesthetics	5
Geriatrics	1
Psychiatry	2
Radiology	2
Physical Medicine	1
Pathology	4

In addition it was intended that 24 junior doctors would be accommodated either 'on-site' or in nearby local-authority housing.

In consequence of the 'Salmon' recommendations the following Nursing Structure was anticipated:

Chief Nursing Officer		1
Principal Nursing Officer		1
Senior Nursing Officers:	Medical & Surgical)	
	Diagnosis & Treatment)	
	Maternity)	4
	Education)	
Nursing Officers:	Labour/SCBU)	
	Wards)	
	Operating Theatres)	
	Central Treatment/ITU)	9
	A & E/OPD)	
	Psychiatric)	
	Geriatric (off sited))	
	Medical)	
	Surgical)	

Implicit in the administration structures described are the following factors, which were planned to 'facilitate using the knowledge and experience of trained nurses to best advantage':

1. The principle of 'progressive-patient-care' inherent in the ward design, and the inclusion of an ITU.

2. Regular comprehensive arrangements for Supply and Disposal.

3. Steps taken to relieve nurses of non-nursing duties.

4. Recognition of the importance of management training.

General Administration:

The general administration was planned around a 'Group' function, and would consist of:

Group Secretary	- Management co-ordinator	1
Deputy	- 'Works, Hotel Services' viz: building/engineering, porters and mail, domestics, catering, gardens, telephones, fire/ security precautions.	1
Administrative Officers	- Main Supporting Hospital and Industrial Zone, Other	1
	- 'Personnel Services,' viz group office, committees, legal, secretariat, staffing	1
	- 'Patients Services', viz med. auxiliary depts, medical records, user sub-committee, major accident, nursing liaison	1
Assistants	- Stewards functions, deceased persons, chapel, shop/library, ambulance service, voluntary help.	1
	- Advertisements, personnel records, health & safety, education and information, general welfare, careers, etc.	1
Group Engineer		1
Domestic Manager		1
Group Supplies		1
Catering Manager		1
Group Treasurer		1
In addition there would be an establishment of clerical officers/personal secretaries/assistants		16
and clerk/typists.		11
(These figures include an additional 3 clerical officers, and clerk/typist allocated to Frimley).		1

Portering:

The day-to-day organisation of portering would rest with a Head Porter and his Deputy. The service would be organised as a combination of the central 'pool' for stand-by and general duties, plus permanent allocations to key departments. Portering functions would include:

... moving patients and bodies
- in and out of vehicles
- between departments
- within depts etc.

... moving information, equipment and furniture,
... night security,
... control of peak visiting car parking,
... supply and disposal - including catering.

The total portering establishment need was estimated at 37, including 6 in the Stores, and 10 in the general 'pool'. Other ancillary staff included 7 telephonists, and 9.5 theatre technicians.

Social Work:

Organised as a 'Group function' this service would be instituted mainly for 'giving advice and reassurance on a wide range of welfare and social problems, to help the patients recovery, and ease return to the community'. An establishment of 4 Social Workers, plus 1 in Psychiatry, plus 1 typist/clerk was intended.

MEDICAL ADMINISTRATION

Within the time available, it was not possible to speak to many medical staff during the evaluation, but comments have been included in the ward/dept sections as and when applicable. Many aspects of medical administration and participation in the management of the hospitals are occuring, and one interesting development is the involvement of community GP's as clinical/hospital assistants.

The following notes were made by the GP chairman of the GP medical staff committee at Frimley Park hospital:

1 When the cottage hospital closed down to make way for the new hospital, both patients and doctors felt that they would be deprived of, and remote from the new hospital. By and large, this has not proved true, and the hospital has improved the medical services in the area.

2 Certain problem areas were developing they included:

2.1 problems of liaison with the obstetric unit,
2.2 problems over the allocation of medical beds,
2.3 the 'inefficiency' of the A & E department, with patients being turned away when not considered true emergencies.
2.4 insufficient geriatric and psychiatric beds, and treatment facilities,
2.5 the waiting list for latent surgery was far too long (some specialties could wait up to 4 - 5 years).

3 In general it was felt that far more praise than criticism was made about the hospital. (One BUPA patient treated as an NHS patient was so impressed that he cancelled his BUPA policy).

4 Generally, GP access to most areas in the hospital is good, and GP's feel themselves to be very much part of the hospital.

The following guide medical establishments are included;

Note these consultants and others are available on a part-time basis at the WS. DGH. Their services are spread across the Region.

SPECIALITY	Consultant/Doctor	Hospital Assistant Technic/Other
Anaesthetic	1	
Anticoagulants	2	
Artificial Eyes		1
Appliances		1
Asthma	1	
Cardiac	2	
Chest	1	
Dental	3	
Dermatology	1	
Diabetic	1	
ENT	2	1
Geriatric	1	
Gynaecological & Obstetric	3	
Medical	3	
Neurology	1	
Ophthalmic	2	
Orthodontic	1	
Orthopaedic	4	
Paediatric	2	
Plastic Surgery	2	
Psychiatric	3	1
Radiotherapeutic	1	
Rheumatology	1	
Surgical	4	
Special Diseases	1	
Thoracic Surgery	2	
A & E)		Hosp.Staff
Pathology) special	3	
Radiology) departments	1	

Note these consultants and others are available on a part-time basis only at Frimley Park Hospital, their services being allocated across the Region.

SPECIALITY	Consultant/Doctor	Hospital Assistant Technic/Other
General Medicine	4	
General Surgery (including vascular)	6	
Gynaecology	3	
Orthopaedics	3	
ENT	3	
Ophthalmics	2	
Rheumatology	1	
Geriatric	1	
Dermatology	1	1
Paediatrics	2	
Plastic Surgery	1	

(list incomplete .... Anaesthetics, Psychiatry, Radiology, Pathology not available).

NURSING ADMINISTRATION

A possible administrative pattern was shown in the planning policies, determined in accordance with the recommendations of the 'Salmon Committee'.

Offices for senior nursing officers (S.N.O.s) and above, were grouped in the main administrative area of the hospital, with accommodation for nursing officers (N.O.s.) decentralised to their individual spheres of responsibility, and sisters offices were provided on a basis of 1 per 34-36 beds in the wards or the equivalent in departmental areas.

The present organisation in both hospitals bears little resemblance to the original, mainly because of NHS reorganisation. The 1970 pattern had suggested:

Chief Nursing Officer

Principal Nursing Officer

Senior Nursing | Medical & Surgical | Diagnosis & Treatment | Maternity | Education

Nursing Officers | Psychiatric | Geriatric | Medical | Surgical | Labour | Wards

OP. Theatres | Central Treatment, I.T.U. Recovery | A & E O.P.D.

The major change has been at Frimley Park where there is a Division of Maternity and Child Health with a Divisional Nursing Officer, an S.N.O, and N.O.s.

Night duty has also been reorganised with an S.N.O. and 4 N.O.s responsible at Frimley Park, and an N.O. and 6 sisters at Bury St Edmunds.

Education at both hospitals is in the charge of a Director of Nurse Education, 2 S.N.O.s, and several nursing officers.

Staffing Pattern:

Staff are deployed to the nursing-officer by the S.N.O. and the nursing officer then deploys them within the unit.

Many staff prefer to work split shifts, and the ward-sister accommodates this as much as possible; ordinary shifts are:

08.00hrs-17.15hrs, or 12.30hrs to 21.30hrs,

The split shift is: 08.00hrs-12.30hrs, and 17.00hrs to 21.30hrs.

One day a week, staff come on at 15.00hrs or go off at 14.45 hours in order to make a short day and the 40 hour week correct.

The night shift is 21.15 hours - 08.15 hours, with an hour off for a meal. Staff work 4 nights on, 3 nights off.

Internal Rotation : Night Duty:

This is not practised other than in the Paediatric Ward, where it is the only way to give the students the required amount of paediatric experience. Generally internal rotation would require more staff.

Office Requirements:

As a result of reorganisation many more offices are required for personnel and training, also community health personnel previously employed by the local authority such as fire officers, security personnel, transport managers and senior planning administrative assistants.

A second training officer was originally placed with the nursing administration (at Bury) but there was no room when the S.N.O.s were appointed. This officer organises study days, the training of nursing auxiliaries, up-dating of health visitor training, and other trained staff.

Night Duty:

The importance of considering the care of the hospital at night,at the early stages of planning, cannot be underestimated. The following points were made either by the S.N.O. at Frimley Park or the N.O. at Bury St Edmunds (West Suffolk DGH), and as a result of the research teams observations at night.

Management:

The administrative pattern needs consideration as there may be an S.N.O. and a number of nursing officers involved. It is more convenient for them if an office can be allocated to them as there are, inevitably, records to keep, interviews, and reports to give. Sharing an office with a day-duty nursing officer is possible but not ideal. Staff are mainly part-time, which works well but increases the need for supervisors and reporting facilities.

Meals:

50 or more staff need meals at night. They have an hour off, and need to relax. The snack bar is the only facility available. It is also used by relatives and there is nowhere for the staff to feel as though they are off duty. In both cases, it is hoped that in future the coffee-lounge could be employed.

Patient Care:

The lighting and observation of the patients in the wards is a worry in both hospitals. Looking from the nurses station into total darkness increases anxiety, particularly as the dependency of the patient on the nurse is thought to have increased (10 intravenous infusions in one ward were observed at one hospital): Night staff would like to see more than 4 patients and did in fact set up a secondary night-time Staff base (as is suggested in the policies). The configuration of the wards - horizontal and contiguous - is found to be very useful; staff help each other in a crisis, and the linked wards are easier for senior management. Staff would prefer no more than 30 beds/ward.

Day/Emergency Unit:

The use of the emergency ward is much appreciated by staff and patients. Observation is good because the light can be kept on.

At West Suffolk-Bury St Edmunds the policies are closely followed. The ward is very busy at night and has to be cleared in the morning ready for the day-patients.

At Frimley Park if the ITU is full, patients are sent to the emergency ward, but often medical cases are sent to the wards - this can cause disturbance. The adjacent Central Treatment suite at Frimley is sometimes used at night and is found useful in preparations for minor surgery, lumbar punctures, chest aspirations etc.

At night children are admitted direct to the childrens ward.

Overnight Rooms:

There are not enought of these for relatives, and often doctors on call use the rooms.

Operating Theatres and Recovery:

The policies suggest that the recovery room would not be used at night, patients would be taken direct into ITU, or into the emergency ward. At Frimley Park it is found more satisfactory to keep the recovery room open, under Day and Emergency supervision. At West Suffolk it is closed.

Permanent staff are on duty in the operating theatres: the sister in West Suffolk also assists in the Accident and Emergency department.

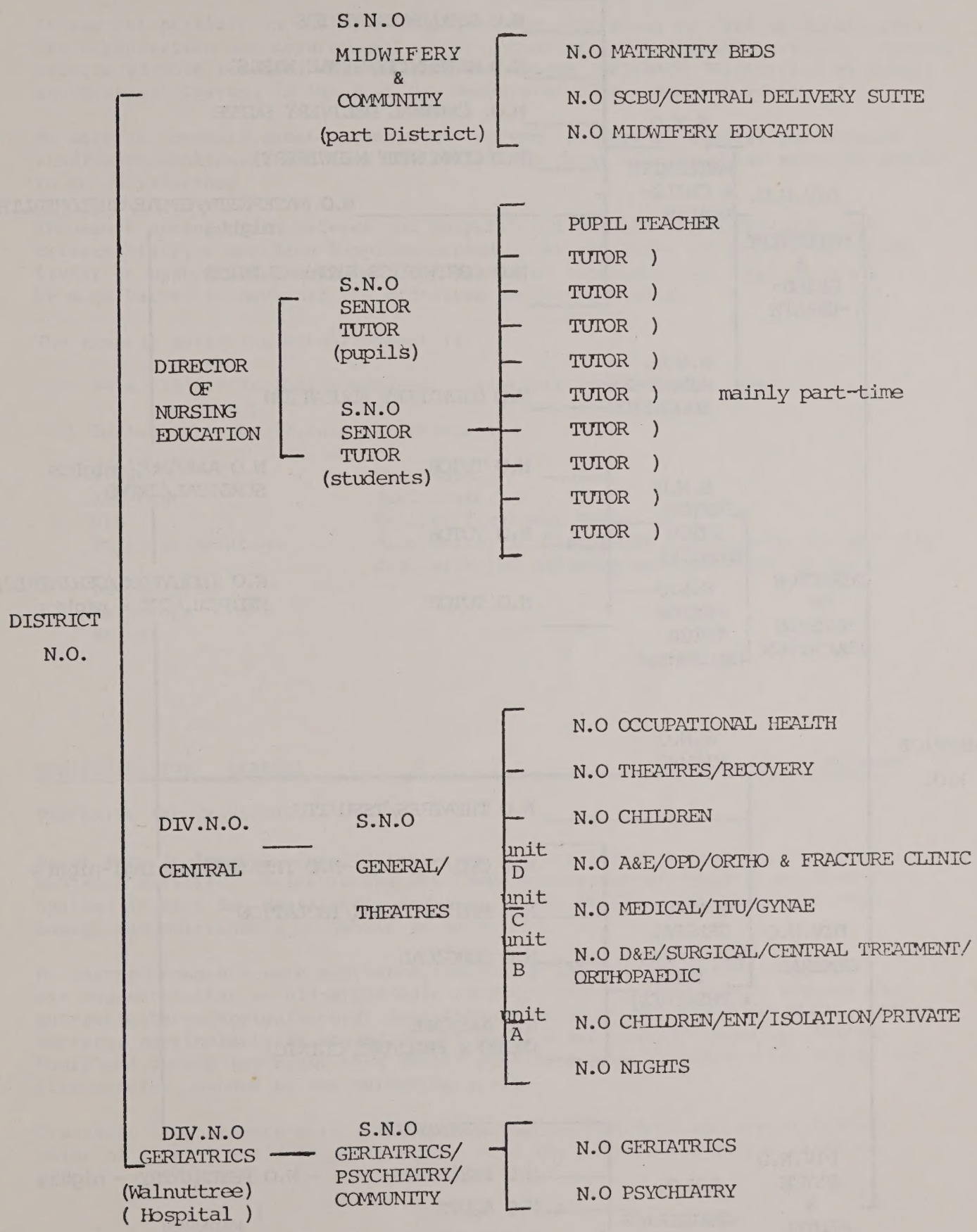
ITU:

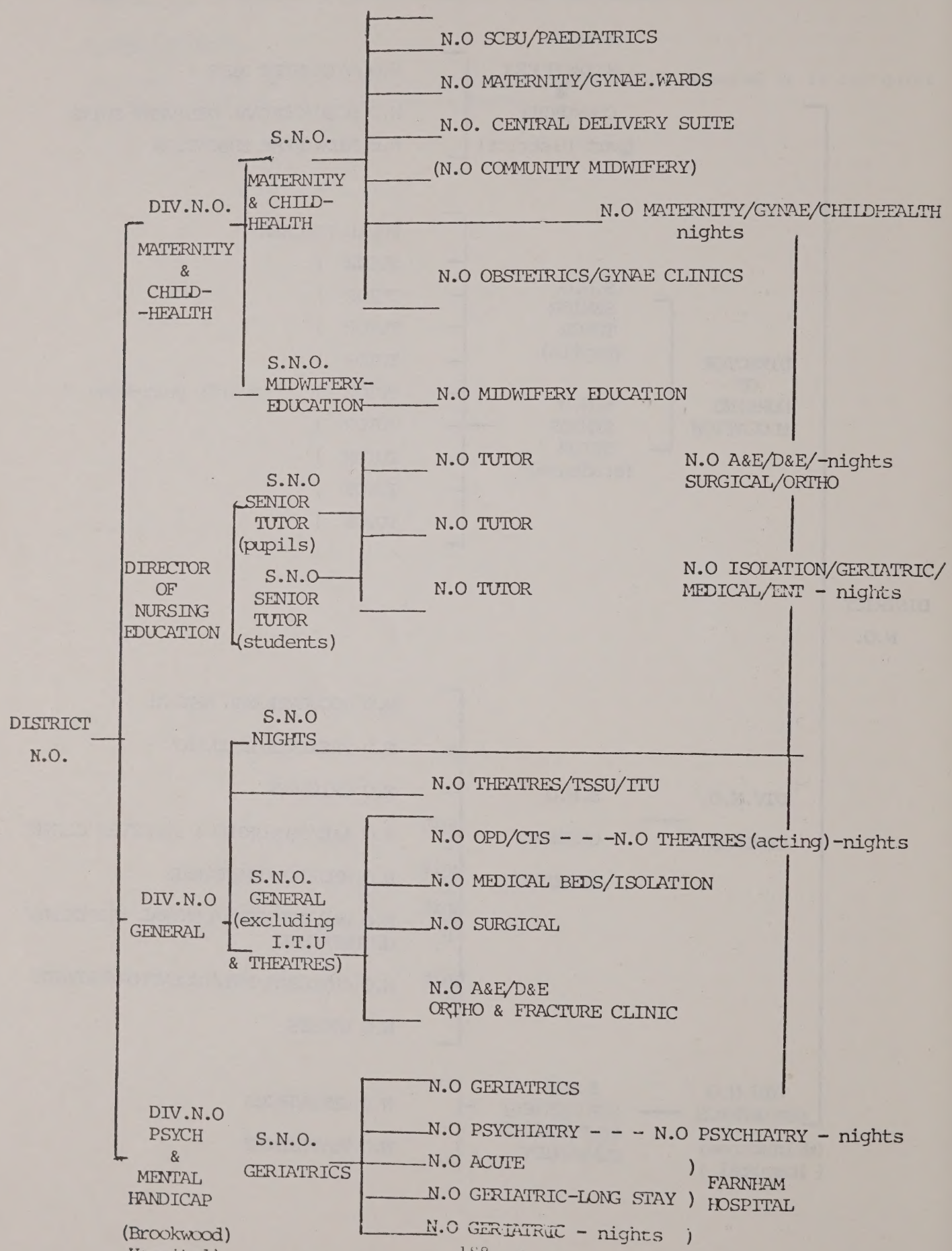
Internal rotation night-duty is used at Frimley Park and the unit is very busy - 2 sisters are always on duty there. A nucleus of night staff are being trained to work in the ITU in case of a crisis.

Fire hazards are the main problems in this unit, and escape (possible in future alterations) through the dining room is not considered a satisfactory solution. (There are no worries about fire escape from the wards).

Communications:

The call system in the wards has problems because if it is muted it is too quiet to hear, unmuted it disturbs the patients.


S.N.O
MIDWIFERY
&
COMMUNITY
(part District)
N.O MATERNITY BEDS
N.O SCBU/CENTRAL DELIVERY SUITE
N.O MIDWIFERY EDUCATION
DIRECTOR
OF
NURSING
EDUCATION
S.N.O
SENIOR
TUTOR
(pupils)
S.N.O
SENIOR
TUTOR
(students)
PUPIL TEACHER
TUTOR)
TUTOR)
TUTOR)
TUTOR)
TUTOR)
TUTOR)
TUTOR)
TUTOR)
TUTOR)
mainly part-time
DISTRICT
N.O.
DIV.N.O.
CENTRAL
S.N.O
GENERAL/
THEATRES
N.O OCCUPATIONAL HEALTH
N.O THEATRES/RECOVERY
N.O CHILDREN
unit D
N.O A&E/OPD/ORTHO & FRACTURE CLINIC
unit C
N.O MEDICAL/ITU/GYNAE
unit B
N.O D&E/SURGICAL/CENTRAL TREATMENT/
ORTHOPAEDIC
unit A
N.O CHILDREN/ENT/ISOLATION/PRIVATE
N.O NIGHTS
DIV.N.O
GERIATRICS
(Walnuttree)
(Hospital)
S.N.O
GERIATRICS/
PSYCHIATRY/
COMMUNITY
N.O GERIATRICS
N.O PSYCHIATRY


DISTRICT N.O.
DIV.N.O. MATERNITY & CHILD--HEALTH
S.N.O. MATERNITY & CHILD-HEALTH
N.O SCBU/PAEDIATRICS
N.O MATERNITY/GYNAE.WARDS
N.O. CENTRAL DELIVERY SUITE
(N.O COMMUNITY MIDWIFERY)
N.O MATERNITY/GYNAE/CHILDHEALTH nights
N.O OBSTETRICS/GYNAE CLINICS
S.N.O. MIDWIFERY-EDUCATION
N.O MIDWIFERY EDUCATION
DIRECTOR OF NURSING EDUCATION
S.N.O SENIOR TUTOR (pupils)
S.N.O SENIOR TUTOR (students)
N.O TUTOR
N.O TUTOR
N.O TUTOR
N.O A&E/D&E/-nights SURGICAL/ORTHO
N.O ISOLATION/GERIATRIC/ MEDICAL/ENT - nights
S.N.O NIGHTS
N.O THEATRES/TSSU/ITU
DIV.N.O GENERAL
S.N.O. GENERAL (excluding I.T.U & THEATRES)
N.O OPD/CTS - - -N.O THEATRES (acting)-nights
N.O MEDICAL BEDS/ISOLATION
N.O SURGICAL
N.O A&E/D&E ORTHO & FRACTURE CLINIC
DIV.N.O PSYCH & MENTAL HANDICAP (Brookwood Hospital)
S.N.O. GERIATRICS
N.O GERIATRICS
N.O PSYCHIATRY - - - N.O PSYCHIATRY - nights
N.O ACUTE
N.O GERIATRIC-LONG STAY
N.O GERIATRIC - nights
FARNHAM HOSPITAL

PORTERING AND TRANSPORT

It was not possible in the time available for this study to deal in detail with the organisation and development of the portering and transport services. Various aspects of both services will be included in the DHSS/MARU 'Evaluation of Supply and Disposal Systems in the Best Buy Hospitals' 1978 - Hazel Grayson.

No adverse comments about arrangements between portering, medical and nursing staff were mentioned, and from the recipients point of view these services appear to be satisfactory.

Transport arrangements between the hospital and the off-sited services, and between District and Area Supplies seemed to be the cause of certain discontent (refer to appropriate sections), and a general conclusion was that it would be much better to have had the off-sited services on site.

The general portering establishment is:

44 w.t.e's - including manager, assistants and 5 charge hands.

Porters are specifically allocated to:

X-ray	Post-Room
A&E Dept	Incinerator
OPD	Central Treatment Rooms
Physical Medicine	Also Geriatric Department. 2 porters specifically deal with the delivery of CSSD items to the Unit.
Day Hospital	
Pathology	
Stores	

PORTERING AND TRANSPORT

As at Bury St Edmunds, insufficient time was available to investigate these subjects directly. Refer to the DHSS/MARU evaluation of 'Supply and Disposal Systems in Best Buy Hospitals', and also to the DHSS/John Guest report about damage and maintenance of fabric in hospitals.

No adverse comments were mentioned concerning the portering service, but it was suggested that an old-style main entrance/enquiry desk should replace the out-patients reception/records desk (the function of which was not wholly satisfactory, particularly in regard to its siting) and that for evening visiting hours and during the night this should provide a general information and directive service, manned by the portering staff.

Transport arrangements were again criticised in that from the administrative point of view it would be preferred to have the off-sited services sited on site.

Ambulance transport is provided by 3 different ambulance authorities. This seems to generate both adverse and complimentary criticism. The reluctance of certain ambulance teams to extend their services to various categories of needy patients or visitors was mentioned by Social Work and Voluntary Services Staff.

The general portering establishment is 47 w.t.e's

Porters are specifically allocated to:

Theatre Suite	Pharmacy
Central Treatment Rooms	Stores
Physiotherapy	2 porters are specifically allocated to
Radiography (X-ray)	Refuse and Incinerator work.

ADMINISTRATION : VOLUNTARY SERVICES BURY ST EDMUNDS

HEALTH AND WELFARE OF PATIENTS

PURPOSE, FUNCTION, ADMINISTRATION AND STAFFING

The co-ordinator of Voluntary Services has her office near the main-entrance in the link connection to Accident and Emergency Waiting area. Starting with 10 volunteers in 1974 the total volunteer workforce now numbers 300. A small number of volunteers are co-opted to work in the ante-natal clinic, and also in Health Centres in the community. Although by notices and public speaking the co-ordinator gains volunteer recruits, many have been previous patients or their relatives.

School children are taken and in particular help the nursery-nurse in the afternoons in the Childrens Ward, but in general it appears that 'Schools want to send them rather than their (volunteers) wanting to come'.

Within the hospital the volunteers carry out tasks in 2 main categories:

1 They work particularly in conjunction with the Occupational Therapists in providing 'diversional therapy' - this is of particular benefit to long-stay and orthopaedic patients.

2 They undertake a certain amount of organisation of groupwork, entertainment, games etc, on a regular basis.

Additionally they 'patrol' the Entrance/Reception lobby providing an enquiry/direction-finding service and helping visitors and patients, generally, with many of their problems. The 2 other aspects of the voluntary work are:

3 Helping in particular with the difficult transport of patients or relatives in such an extensive rural catchment area, and

4 Ensuring upon patient discharge that neighbours and community services are alerted - where appropriate

ACCOMMODATION : ENVIRONMENT

In general the volunteers have said that they and the patients are 'favourably impressed' by the building and its environment; particularly, there seems to be no typical 'hospital-smell' - even in the Geriatric areas.

Criticisms were connected with the problems of 'lack of confidentiality' (sound) in the offices, when interviews take place, and the problem of signposting. It should be borne in mind that even with clear and adequate signposting, patients or relatives may often come in a state of anxiety and need help to prevent their becoming confused. In this latter respect the volunteers help patients to the X-ray department, and also fetch and carry prescriptions from pharmacy to the out-patients.

ADMINISTRATION : VOLUNTARY SERVICES FRIMLEY

HEALTH AND WELFARE OF PATIENTS

PURPOSE, FUNCTION, ADMINISTRATION AND STAFFING

Within the hospital the co-ordination of Voluntary Services comes under one Supervisor who has an office in the Administration department.

There is a total volunteer workforce of 480 people mainly connected with Frimley Park hospital, although a small number also go to help at family-planning clinics in the locality. The volunteers are normally adults, as children cannot be expected to be available from school on a sufficiently reliable and regular basis - in fact the schools tend to use the hospital as a training service environment for the benefit of their own pupils.

The work the volunteers do is roughly split into 4 categories:

1 They provide back-up help for the Housekeeping staff every morning (2 volunteers/ward).

2 They provide an efficient information and enquiry/direction service in the Main Entrance passing people on to the place/person/information that they require (this has been instituted because the main reception desk only deals with records, and booked inpatient or out-patient appointments).

3 They provide a volunteer car-ferrying service at the request of the Social Workers, in conjunction with administration and NHS management.

4 They provide a radio-broadcasting service to the whole hospital.

In addition, the library trolley service and organisation of delivery of flowers to the wards is undertaken by voluntary staff, and the concourse shop is run by the WRVS.

Because the Ambulance Services will only cover a certain type of transport need, the volunteers have been organised to fill many of the loop-hole cases. For instance the ambulance services would not provide transport for a psychiatric patient returning home for a weekend on his doctors recommendation. The people transported by the volunteers fall roughly into 4 categories.

a Visitors - with social or medical grounds, and perhaps elderly patients.

b Feeding Mothers - where the mothers have been discharged but the babies have to stay in hospital ... 'the ambulance services won't touch them'...

c	Patients with Special Needs	- including visiting arrangements prior to discharge to Local Authority part 3 accommodation.
d	Out-patients	- those who would not come under their own volition but whose attendance is thought advisable by medical staff.

ACCOMMODATION : ENVIRONMENT

The hospital appears to have provided 'the nicest ... environment ... I have ever worked in' - Co-ordinator.

The siting of the hospital is considered good, and the problems of patient/visitor travel in the locality are seen to be the psychological reorientation to the new focus of medical activities.

The only other comments concerned signposting internally (the difficulties of finding the exit etc) and the lack of space for wheelchairs - in the Entrance this is probably due to the congested bay by the doors which has been converted to use as an Information Desk manned by volunteers.

ADMINISTRATION: SOCIAL SERVICES BURY ST EDMUNDS

HEALTH AND WELFARE OF PATIENTS

PURPOSE, FUNCTION AND ADMINISTRATION

The Social Work is split into 2 categories (general and psychiatric) and both maintain a comprehensive link with services in the community. In particular the WRVS are well organised and help with local problems of transport, clothing, rehousing and so on. The Local Authority is also considered helpful, and is involved with the running of the day hospital and community clinics.

Little information on the organisation of social work in the hospital was obtained, but it understood that in conjunction with help from the Voluntary Workers a fairly comprehensive service for patients their relatives and visitors is maintained, and that there are adequate facilities to enable the Social Workers to carry out their particular roles in patient contact and support.

ACCOMMODATION

Pressures on office space were not thought to be great and the Social Workers have moved from the outpatients department to an office in the Administration area.

ADMINISTRATION: SOCIAL SERVICES FRIMLEY

HEALTH AND WELFARE OF PATIENTS

PURPOSE, FUNCTION, ADMINISTRATION AND WORKLOAD

The Social Work Service in the Frimley Park hospital plays an integral role in the pattern of patient care dealing with all referrals except psychiatry patients, within the hospital - about 2000 in 1977 - and maintaining links for continuity in the community.

The majority of patients seen are inpatients and the social worker is involved directly with the ward staff. The only exception is paediatrics: a majority of the children are seen in the paediatric outpatient clinic and others are seen at the Frimley Childrens hospital, where there is a paediatric assessment centre. The Social Workers are distributed around the hospital to co-operate closely with the workload of each department.

1 Social Worker (plus an assistant) is allocated to the geriatric ward (the geriatric patients at Farnham hospital are also seen). The Social Worker attends the ward rounds and maintains supportive information on home-backgrounds and alternative community care. Nearly every patient is seen as a social-work case, and the workload is considered to be at saturation level. 4 Social Workers are allocated to work on the surgical, gynaecology and medical wards which are busy and have a high throughput of patients, and 1 Social Worker is allocated to each of maternity, isolation, and the chest-clinic.

A standardised system (Surrey) for assessing patients is now used, and the pattern of ward-work consists of being notified and discussing with staff, reviewing notes, letters and records, seeing the consultant, and then talking to the patient. Accident and Emergency admittances through Day and Emergency beds are seen on the day following admission. A cause for particular concern is the increasing numbers of drug-overdose admissions.

Two areas of care do not come under the Senior Social Worker, these are psychiatry- where the psychiatric Social Workers maintain links with community Social Workers from Hampshire and Surrey -, and community social work organisation which is co-ordinated by a District Social Work team.

The total staffing establishment stands at:

8 full and part-time	
1 principal	(f.t)
2 assistants	(f.t)
6 Part-time Social Workers and assistants.	

ACCOMMODATION

The principal Social Worker, her assistant and the secretaries have their offices in the outpatients department, where some records and files are kept. Other offices are distributed around the hospital and two offices built into the waiting-areas in the first floor corridors now house the secretaries and the greater proportion of the files and records.

The sharing of rooms is seen as the biggest disadvantage which-coupled with the poor acoustic attenuation - makes it difficult to hold confidential interviews. In this respect, siting the offices adjacent to the outpatients waiting area has not helped.

ENVIRONMENT : ENGINEERING

Several comments include:

1 The level of noise generally in all areas of the hospital is tiring and specifically its lack of control makes confidentiality a problem when interviews are being held.

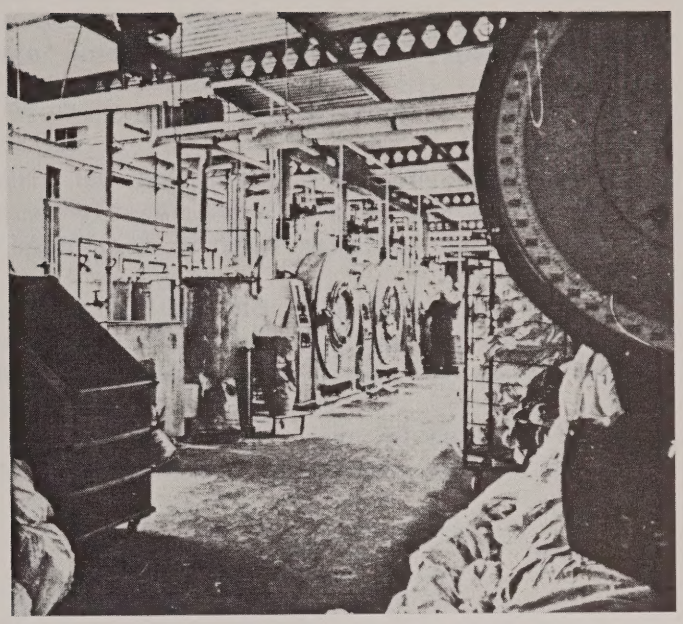
2 The staff find the nursing stations lack privacy for the reviewing of notes and discussions with ward-staff about patients.

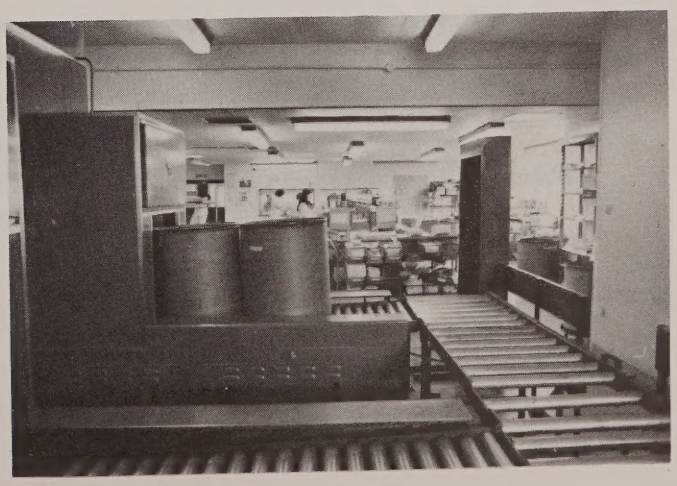
OTHER

Facilities in the community are felt to be lacking (although some of the problem may be accessibility - see 'BACKGROUND INFORMATION - CATCHMENT AREA PROFILE') and in particular the Social Workers feel there is a need for more sheltered housing, and old-peoples housing.

Transport and visiting for patients and visitors has also been a problem in the past. The hospital car service and the ambulance service maintain a tight definition on whom they will transport. However, this problem has disappeared and in liaison with the Voluntary Workers the availability of transport is thought to be very good.

Off-sited Services.





OFF SITED SERVICES: LAUNDRY AND CENTRAL STERILE SUPPLIES DEPARTMENT

(For SUPPLIES: see Supplies, Storage and Distribution)

(For TRANSPORT: see Administration)

(See also: 'Background and General Information' and 'Conclusions for Development and Change' and 'Departmental Relationships')

LOCATION AND DESCRIPTION OF DEPARTMENT

It was decided that these departments would be considered from the continuing usefulness of those services and facilities already available to the catchment area. On-site capital works were to be kept at a minimal rational level.

At Bury St Edmunds the Laundry and CSSD are sited on the St Mary's site 2 km (1 1/2 miles) from the new DGH. The Laundry has been added to and improved, the CSSD is a new 'temporary' unit which is envisaged to operate for many years.

At Frimley, the Laundry and CSSD are at Farnham hospital about 10 km (6 miles) distant from DGH. They are housed together in a new unit capable of meeting the needs of an expanded Area Service.

PURPOSE, FUNCTION, AND ADMINISTRATION

Laundry:

At both hospitals it was intended that the Laundry manager would work in co-operation with the supplies and transport managers.

The Operational Services managers co-ordinate and control communications between Laundry, CSSD, and the Hospital departments.

Steam supply was available (off-sited) at both locations and this affected the decision to have only low pressure hot water roof-top boiler-houses at the hospital itself. Within the constraints of no departmental expansion, this has been entirely satisfactory.

Supply and disposal arrangements for both new DGH's affect the Laundries in different ways. Planned on an exchange trolley system, used linen is sorted at ward department level and colour bagged in two categories either for special pre-treatment, or for normal laundering. After processing, at Bury St Edmunds linen is condemned and/or repaired at St Mary's before being returned to the DGH. At Frimley this task is undertaken at Farnham. Most linen from Theatres and TSSU is bagged and processed separately, returning to the hospitals via CSSD. Certain other items are returned direct.

Central Sterile Supplies Department:

At Bury St Edmunds the CSSD manager organises the service (part-district only) in conjunction and under overall control of the Operational Services Manager.

At Frimley the CSSD manager operates a 2-district service. Transport for both services remains off-sited at the same locations, this is supplemented by a small transport allocation on-site at Frimley DGH. The transport at Farnham is organised as a district pool resource.

PURPOSE, FUNCTION AND ADMINISTRATION

As with supplies, after NHS reorganisation, the Area organisation of this department became based at Ipswich rather than at Fulborn.

As planned the laundry caters for two categories of linen; soiled or foul and infected. Normally the latter should take up about 10% of the work load, but it is currently running at approximately 23%. Some of this is probably due to incorrect bagging at Ward/department level.

Some details of the service are not completely satisfactory in the managers view because of the long delays and trouble with the internal transport system.

Whilst the laundry is gradually up-dating its equipment, the system is run on a series of manually controlled production lines, the clean laundry is gathered and if necessary condemned and/or repaired in adjoining rooms. Theatre/TSSU linen goes on to CSSD for checking and re-issue.

The original policy of returning linen to DGH for sorting fell foul of on-site space in the supplies block, so now there is Regional allocation to take laundry trolleys by transport from the DGH on an exchange trolley basis. A full trolley always replaces one already in use, so no ward/department is ever without.

WORKLOAD AND STAFFING

The staffing allocation seems to be satisfactory and there are 'teams' of people allocated to various stages in laundering, including special clothes-care-processing for geriatric and patients' clothes and some staff clothing and uniforms.

The figures in the Planning Policy are no longer representative; present ones are:

HOSPITAL	BEDS	PIECES/WEEK	
Jane Walker Hospital:	175	5,250	
Newmarket general :	291	17,260	
Risbridge :	239	7,170	
West Suffolk DGH :	540	41,970	(nearly 50%)
	TOTAL	71,650	

The total represents an increase of 30,000 pieces per week on those estimated in the policy, some of which is probably due to the new Geriatric Block at the West Suffolk DGH. The unit is therefore working at stretched capacity.

ACCOMMODATION

As was stated in the policy, the existing unit continues to be used with minor modifications. Both managers at Bury expressed a preference for being on-sited, which would alleviate some of the transport problems and prevent costly damage to the linen trolleys which were not designed for external manoeuvring.

The entrance-loading dock is openly exposed to the weather, causing unpleasant working conditions. This area is the only area where severe congestion (of dirty linen bags) occurs.

The accommodation appears adequate and the layout of machinery (which is becoming outdated) allows good circulation space. The linen progresses on a direct throughput route to a separate clean laundry exit.

Staff washing and WC facilities are poorly dispersed, but changes are being made to modify this situation.

ENVIRONMENT AND ENGINEERING

Day lighting is moderately good although north lighting would have been preferable to rooflights and the west window curtain-wall, with which are associated all the problems of solar gain/loss.

The machines are being up-dated, but the rate of replacement is slow, and new and better layouts would enable space to be used more conveniently.

LAUNDRY FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

To some extent NHS reorganisation has affected this department. The Laundry acts now as a 2 district laundry and will continue to serve the Guildford district as hospital services develop there, whilst also serving the Frimley district.

One third of the laundry capacity is retained for use by the Surrey County Council for service to homes (or Cottage Hospitals) and schools. Transport, based at the same location, is organised to deliver on a 'district-round' accordingly.

Originally a return-to-user system was operated, but this has been supplanted by a district linen 'pool' with bulk return to the DGH where some sorting takes place. On site at the DGH there is a partial exchange-trolley system, but the exchange takes place at supplies block rather than at department/ward level, which does leave those areas without a trolley for certain periods.

Foul and infected and soiled linen are dealt with individually, though the notional/national average of 10% workload for the former is proving to be nearer 30%-38%, which has serious implications on staff allocation (see Conclusion).

TSSU linen is processed and returned via CSSD to the DGH.

WORKLOAD AND STAFFING

The staffing allocation of between 25-30 seems adequate, although operations are affected by the coincidence of sickness, holidays and the high load of foul and infected linen.

The use of self-wash (national) nurses uniforms has considerably reduced the expected workload; they anticipated 1200 uniform bundles a week and in actual fact have 70 a week.

300 pieces/week are done for Surrey County Council, but for the hospitals the breakdown is now:

HOSPITAL	BEDS	PIECES/WEEK
Frimley Park	554	25,000
Farnham	190	8,000
Fleet	30	1,200
	TOTAL	34,000

The total represents a decrease of 10,000 pieces/week on the notional figures for Frimley Park given in the policy. However, spare capacity is maintained for the growth of demand by the County Council and by South West Surrey District. The unit is therefore running towards an even balance, but not at capacity.

ACCOMMODATION

The new Laundry/CSSD building appears to have been well designed with an efficient gravity feed semi-automatic process installed, operating from the first floor through tunnel bags, through the machines to where the linen is sorted and folded. In some processes it is easier to train people to sort, fold and stack than to run excessive machinery, so the sophisticated gravity storage racks are not in use because this would put further demands on staffing.

The loading-bay and machinery for foul and infected linen is being modified to ease sorting and speed the throughput of bags. Circulation space generally is adequate, though tightly planned.

Staff facilities are shared with CSSD and appear spacious, they include canteen/meetings area.

ENVIRONMENT AND ENGINEERING

Lighting is good and daylighting is adequate, though the tinted glass (presumably to reduce solar-problems) on peripheral walls reduces this considerably.

The machinery is noisy and there is a certain fluff problem which may be attributed to the mechanical processes involved.

CSSD — BURY ST EDMUNDS

PURPOSE, FUNCTION AND ADMINISTRATION

The CSSD handles mainly instruments and is well laid out to do so, operating with 2 throughput 'bin' autoclaves and 2 front loading autoclaves.

TSSU recycle their own instruments, but CSSD check and issue gowning and soft-dressing packs.

Sterile fluids are issued by the department, but are no longer manufactured here (coming from specialist suppliers organised by the Area authority).

CSSD also order and issue syringes - mainly disposable ones; all other disposable items (such as catheters) are ordered and supplied direct to the stores, either onsite or adjacent to CSSD at St Mary's hospital. Community nurses/health personnel and clinics are also supplied.

WORKLOAD AND STAFFING

2000 beds were lost from the catchment area at NHS reorganisation but the CSSD is now supplying about the same number including various hospitals in Cambridge, in Royston and in Essex. 3 hospitals in Huntingdon are supplied, 1 in Papworth and 1 in Ely. The supply also covers District Nurses, GP Practices and Family Planning clinics in Bury St Edmunds district.

Training and techniques at hospital level have affected the extent of service and the other major factor of change is the use of disposable equipment which is still tending to increase.

Staffing levels appear to be adequate.

ACCOMMODATION

The CSSD unit (though supposedly temporary) is well built, well laid out and adequate in the layout and processing areas. The storage and racking areas are split and rather congested, while the loading entrance bay for processed materials is minute and poor for circulation and operation.

Staff accommodation is adjacent and reasonably sufficient.

ENVIRONMENT AND ENGINEERING

All aspects seem adequate and satisfactory. The light structure of the building, however, gives rise to some problems of ventilation and heat-gain in the summer months.

The card-tubs and throughput autoclaves, working on a part-conveyor system, seem to be very satisfactory.

CSSD FRIMLEY

PURPOSE, FUNCTION AND ADMINISTRATION

The CSSD at Frimley is organised to serve 2 districts (West Surrey/NE Hampshire, and SW Surrey and will assume full capacity workload when the hospital at Guildford is completed.

The manager prefers to be off-sited due to the dispersed workload, and because it enables him to manage autonomously with greater efficiency. Area and District Health Authorities, however, would prefer the unit to be on-site, as the new DGH has become a focus for health care in the district and therefore generates the greatest workload. Topping-up at hospital level is not operated, in contrast to the expectations of the planning policies. The system implemented is a date-coded door-tag punch-card system, and departments are supplied with sufficient packs for 3 1/2 days use. The packs normally cover weekends and holidays, although extra amounts are sent to Accident and Emergency whose use is higher during these times.

Emergency requisitions, bandage packs and gown/linen packs only are supplied to TSSU, who maintain their own ordering and stocking system and use the Supply Block on-site for bulk break-down and separate storage.

It is thought that a lot more general bulk break-down could have taken place at DGH if sufficient space had been allowed.

When punch-cards are lost or thrown away, supplies at ward/department level sometimes run down; other losses are due to theft although the card system helps control this situation.

WORKLOAD AND STAFFING

The extent of the CSSD service at this moment stands at aproximately 1400 general hospital beds plus 1500 psychiatric beds/places.

The catchment/supply area includes:

Farnham Hospital, Camberley Day Centre (Geriatrics and Day cases). Northfields (Mental deficiency), Frimley Childrens Centre, Fleet Hospital, Hydestyle - Godalming, Haslemere, Brookwood, St Luke's - Guildford, Royal Surrey - Guildford, Frimley Park DGH, Cranleigh Village Hospital.

3 GP Practices (local) and 11 Health Centres, Surgeries and Clinics, Fleet Family Planning Clinic and Community Nurses are also served.

There are 6 front loading autoclaves which are sited in spacious and well ordered accommodation. At the moment 1500-2000 dressing packs/week are prepared and TSSU linen is folded and prepared.

Staffing is adequate at 28-30, although the numbers may fluctuate with a) the opening of the new Guildford hospital and b) the indefinite but probable increase in the use of disposable items.

ACCOMMODATION

This is spacious and well-designed. There is adequate space to change work-benches and storage layout should this ever be necessary.

Staff facilities are shared with Laundry Staff in the same building and appear to be satisfactory.

ENVIRONMENT AND ENGINEERING

All aspects appear to be satisfactory.

Farnham Laundry and the CSSD have their own on-site maintenance teams and the arrangement appears to work well.

OFF-SITED SERVICES

CONCLUSIONS

LAUNDRY

The decision taken at the time of 'Best Buy' policy planning, to off-site Laundry and CSSD and other storage in order to reduce on-site on-costs, was fair in principle. Unfortunately that principle ignored the wider detailed issues of:

1 The new DGH becoming the focus of medical care for a health-district with a complicated logistical need for transport, supply and disposal services that could not easily be 'latched-on' to what existed already.

2 The development and expansion of the hospital departments which affect the loading on and the need for a closely related servicing facility.

3 The possibility of the restructuring of the NHS which indirectly affects the way laundry and supplies are controlled, handled and requisitioned, both at ward and departmental level and servicing levels.

4 The detail of transport organisation within and without the hospital and the time and communication problems associated with (in Frimley's case particularly) distant supplies.

5 The physical planning problem of placing the receiving and distribution centre with stores and disposal at the rear of the hospital - thus 'locking' the use of space and circulation in a position valuable for departmental redevelopment (although in fact major expansion was never intended).

Quite possibly, even if such services had continued to be off-sited, the industrial' zone at the rear of the hospital could have been installed to one side, given greater flexibility in Frimley's case to Government and Local Authority use and requisition of land.

Alterations:

It is notable that both at Bury St Edmunds and at Frimley, the service/stores block has been altered in order to make the policy work. The problem seems to have been the detailed planning of laundry and circulation space and the positioning of entrances and loading-bays.

In both cases, too, it is a great shame that a light translucent cover or canopy covering a large area around all entrances and loading-bays of the supplies block could not have been provided. There is no way that lorries, vans etc can drive up and load/unload completely under cover, and at West Suffolk cars obstruct the vans' access occasionally. At the moment the system operates literally inside-out, and the endeavours of the drivers to gain more shelter and convenience for their operation has resulted in a lot of damage to the building fabric.

Losses:

It is evident that losses and/or misuse of laundry are a persistent problem, they may reflect a problem which is national in scale. At Bury St Edmunds they stand at around 20%, which has to be 'evened out' over the various hospitals. At Frimley they stand at between 10% and 15%. Attention to this problem is drawn in further detail in the section on 'Supplies'.

Distribution of Waste-Return Linen:

As has been pointed out, the returns of foul and infected linen (including those from Theatres) is rather higher than the national average; 23% at Bury St Edmunds, 30% + at Frimley. It is believed that some of this is due to a lack of understanding, training and perhaps communications between laundry and Hospital/ Nursing management.

Because it is far easier to strip a bed by lifting all four corners (sometimes including blankets) and putting all the used items in one bag, this practice tends to overload this side of laundry. A work study at Frimley has revealed some of these problems. (See work done by Regional Work Study Teams).

CSSD

The main problem observed by both CSSD managers has been the rate of loss of packs and equipment.

Bury St Edmunds also appears to be using a larger number of dressing packs at ward level than was expected, which suggests a higher number of dressing procedures being undertaken on the wards rather than in Central Treatment.

However, this factor is insignificant when compared with the rate of loss of dressings and equipment in all departments. External or temporary hospital users may be partly to blame, staff-user education and communication needs to be increased and the security of the stores areas at ward/department level poses some problems. This problem is causing concern, but it must be reviewed in the light of national trends and behaviour.

Conclusions.

Inevitably these conclusions must summarise and generalise about what has already been discussed in detail; they are intended to put the hospitals into context with their individual and common problems of development and change - particularly with regard to 'external' catchment area influences, and to 'internal' organisation and opinion.

Inevitably too, whilst the evaluation team tried to be as objective as possible in writing up the reports, they had to rely on commentary and the method of questioning was specifically set up to reveal changes, problems and faults.

The individuals interviewed welcomed the opportunity to contribute to the evaluation and were able to speak quite openly about some of the aspects of design and organisation that troubled them most. However, nearly everyone interviewed reflected that whilst they had spent a lot of time contributing criticism, they felt it important to stress that the hospitals presented a very pleasant working environment.

The research team were unable to interview patients (within the parameters of the research commission) but from observation and comments heard, it appeared that the public, as hospital users, were 'taking-to' this new facility in a very positive way.

Whilst the conclusions will try to cover a wide range of relevant points that were revealed during the period of study, the terms of reference of the research were to investigate the currency and validity of the 'Best Buy' planning principles as interpreted in design and current departmental modes of operation.

It was decided to use the 'Planning Policies' rather than the hospital 'Operational Policies' as a monitor because not only are they more consistent - covering both hospitals equally - but they also reveal the intentions of the planning team before the hospitals were actually commissioned.

Where policies were actually changed by the DHSS prior to final commissioning, but after the writing of the planning documents, comment has been included if significant attention was drawn to them. However, as the object of this research was to assess the value of the policies of 'Best Buy' planning, as written, some of the commentary will inevitably include criticism of the hospital design that has already been taken into account.

Level of Activity:

Although Frimley Park claimed to be very much busier than Bury St Edmunds (West Suffolk DGH) in certain departments this was not substantiated by observation. For example, on certain mornings, not a single patient was observed in Accident and Emergency, Orthopaedic and Fracture Clinic. Only 2 patients were in ITU/CCU and in the mid-afternoons, 3 or fewer of the Theatres were in operation, and only 1 patient was in the recovery room.

To be fair, at night a converse situation was true; there were large numbers of highly dependent patients in the wards, and a substantial number of sisters and trained staff were on duty and busy!

Study of Work Patterns:

For several departments where we have been quite critical - such as 'Catering' and perhaps the 'Out-patients Department' - we suggest that detailed study of

the patterns of workflow are urgently required. A great deal of pressure is placed upon the Nursing Officer or Head of the department to achieve an effective use of space, and considerable problems were revealed by our research - these are pointed out in detail in the appropriate sections. The design of the building cannot be expected to work if the patterns of work are not apparent. However, having said this, in other areas such as on a number of wards, and in the Operating Theatre Suite, numerous changes in work patterns have been successfully accommodated without designed physical impedence.

Change in Catchment Area:

Undoubtedly the major area of change affecting the hospitals is the development of the populations for the catchment areas, and indeed the change and increase of the catchment areas themselves. The original estimates given in the policies projected a catchment population (foreseeable several years after commissioning) of about 170,000 people.

Bury St Edmunds has already exceeded this, the figures fluctuate between 178,000 and 195,000 people. There are several possible factors here:

1 The availability of different types of beds within the new catchment area has changed, and this has affected demand on certain specialties.

2 Larger hospitals at Cambridge and Ipswich and others at Newmarket have acquired long waiting lists and some of the patients are being syphoned off to the West Suffolk hospital at Bury.

3 The area and region as a whole have recently seen the influx of an elderly retirement-group population, and additionally Essex and Suffolk have become an overspill area for the resettlement of families from London; this influx is contributing to a growing psychogeriatric problem which may necessitate the development of the hospital.

The following list of desirable development projects may indicate in more detail the areas considered to be most needy of change or development.

Project Description/Planning Priority	Financial/Planning Implications
207 Bed Psychiatric Unit with Day Facilities	Major
Education/Training Complex on-site	Major
On-site Medical Staff Residences	Intermediate
On-site Staff Residences	Intermediate
Hydrotherapy Pool	Intermediate
Younger Chronic Sick Unit	Intermediate
Sports and Leisure Centre	Intermediate
Pharmacy Store and Manufacturing Unit	Intermediate
X-Ray Records Extension	Minor

Medical Records-Microfilming	Minor
Staff Coffee Lounge - Extension	Minor
Staff Dining Room - Extension	Minor
Snack Bar - Extension	Minor
Workshop - Extension	Minor
E.B.M.E. Technicians Workshop	Minor
Nursery Group Accommodation	Minor
A & E Forward X-Ray Facilities	Minor
O/T Activities Centre	Minor
Orthopaedic/Geriatric Ward	Minor
Medical Staff Mess-Room	Minor

Frimley Park has seen a totally unprecedented catchment area population increase to between 240,000 and 260,000 despite the fact that the current catchment area is approximately 1/4 size that of the West Suffolk hospital at Bury St Edmunds. Whilst the catchment area at Bury still retains rural characteristics and because of its geography suffers from difficult communication, transport and logistical back-up services, that at Frimley maintains or supports a way of life that centres at London. Public transport is efficient and covers most districts and there is a high percentage of car ownership.

The problems at Frimley Park have been those of over-demand for the adult acute beds, and the pressure for bed use has resulted in a much quicker throughput of patients than was foreseen. The number of community services and surrounding health facilities is sufficient to cope with this, but depends upon extensive and co-operative communications between different managerial hierachies.

Whereas Bury has a one-District management organisation, at Frimley the management is complex. The new DGH comes within a two-District management structure, but support services are shared also with the Local Authorities and County Council. The ambulances are run by three separate authorities and community facilities and services are split between Hampshire and Surrey in many different Local Authorities (see Catchment Area profile).

Priorities for the development of the hospital at Frimley are frustrated by the restricted site which is hemmed in by roads and housing estates. Some adjacent land belongs to the Ministry of Defence - this is the only area which could allow 'on-site' development.

Detailed desirable development plans were not available but commentary from all levels of management suggest a pattern similar to that at Bury:-

Project Description/Planning Priority	Financial/Planning Implications
Obstetrics/Gynaecology Unit	Major
Education/Training Complex	Major
Additional Adult Acute Wards	Major
On-site Medical Staff Residences	Intermediate
Hydrotherapy Pool	Intermediate
X-Ray Department - Extension	Intermediate
Additional OPD Facilities	Intermediate
Psychiatric Day Facilities	Intermediate

Best Buy Planning - A General Perspective of Design and Development

Up to this point, commentary and information has either been specifically related to a department, or to generalisation about catchment area changes.

The following points are contextual from the District and Area Management points of view.

Bury St Edmunds:

1 The hospital was a 100% bonus to the district and is the basis for development and advance ... 'Everyone is so damned interested ... '.

2 Generally 'Best Buy' planning is considered good, but logistical detail, and the detailed structure and capital costing is proving unsatisfactory, particularly in regard to revenue consequences. 'What was vital was to look at the way money was deployed', the district 'pays through the nose' to upkeep the services and maintain the fabric.
... 'a total inbalance was created ... '.

3 One of the biggest problems in communication (authority and transport) is the policy of off-siting Laundry, CSSD and supplies.

4 Community integration is good and the policies have worked. However, some of this success is due to the readiness of personnel and management to implement new patterns of work prior to the commissioning of the hospital. This indicates how essential it is that local opinion and co-operation is sought prior to policies being finalised. Flexibility of operational policies must be encouraged - the current economic and planning situation of the catchment area has affected the operation of all departments in the hospital.

5 Bury have proved that 'Best Buy' can be developed - this is not generally acknowledged. Within the spectrum of care of the local health facilities, the commissioning occurred in stages and new units have been added and are still being planned.

6 NHS reorganisation has not only affected the catchment area and the services it now expects of the hospital, but it has additionally caused terrific management problems. 10 people now carry out the work originally allocated to the Hospital and Group Secretaries, nobody is truly 'the captain of the ship' and there is more probability of conflict between 'line management' and 'functional management', and between different tiers of responsibility within the departments. This problem has little to do with Best Buy hospitals as such, but indirectly it has not helped to encourage the co-operation needed between different staff especially where running the innovations of Best Buy is concerned.

7 Design details throughout the hospitals might have been satisfactory if cheap materials and systems had not been used regardless of maintenance and environmental considerations. The engineering and works staff have been stretched to correct faults, blockages, damage and to provide 'planned preventive maintenace'.

Another problem has been the limitations of the engineering system which is not sufficiently flexible to provide for the natural development of the hospital.

8 Noise and ventilation cause problems throughout the hospital (see individual section conclusions for details) but particularly the lack of confidentiality for consultations and examinations has been a major headache; it is related to structure, materials, furnishings and the pattern of ventilation, and the relationship of waiting areas to 'interview' rooms.

9 Catering has been a major problem. The policies have not worked, and the kitchens are poorly designed. There is a high rate of staff illness in that department and consequently an 'Environmental Health' team has been set up to investigate the problems.

10 The Day and Emergency and Central Treatment Suite have found favour with a large number of staff. 'They are useful innovations but whether they result in better patient care is questionable'. This is a complex issue to assess, because nursing duties, teaching and organisation has dramatically changed since the planning of the hospital took place.

11 Generally because of the wider spectrum of patients being taken the hospital services have had to change and be flexible. Length of stay has changed because patients were previously going out into the community too quickly for the community services to cope, and medical attitudes to care are chaning. Also, the policies of doing as many tests on prospective inpatients before admission as possible, has 'not always been possible'.

12 Litigation is felt to be 'creeping in' and legal requirements such as those in the 'Congenital Disabilities Act' are now affecting not only hospital procedures, but indeed the space allocated for certain departments, such as X-Ray and Medical Records.

13 The wards are generally liked (once the nurses got used to working in them). The success of them is resultant upon the back-up ancillary spaces - particularly WC's and washing facilities. It is felt that the wards are more flexible than other types and that 'Nightingale wards would not be liked'.

14 Finally, the evaluation has been too slow in following the commissioning. The optimum time should have been three years afterwards. But the findings will be useful to all departments, although it should also be borne in

mind that a patient/user response is urgently required. It is difficult for the hospital to know how well they are caring in the eyes of the public.

Frimley:

1 The Frimley Park DGH has become the new focus for health care and has unexpectedly had to provide for a much larger catchment area population. One of the problems is that is not particularly related to any one centre of population or local authority services.

2 The hospital finds itself working at capacity under pressure, because in many instances the staffing establishments were never achieved. DHSS incentive bonus schemes were responsible for fixing staff levels between 75% and 90% at the time of commissioning, and it has been difficult to correct the imbalance of numbers as the patient load increased.

This has partially resulted in a very high throughput of patients, which in turn has affected the categories of patient dependency. The hospital is very much an 'acute' facility.

3 The 'off-siting' of Supplies, CSSD and Laundry has not been 100% successful and has resulted in transport and communication being allocated 'on-site' to cope with changes in organisation.

4 The site is felt to be very constricted by its boundaries and there is a particularly urgent need for on-site Geriatric and Psychiatric day facilities, for additional OPD space and for rationalised maternity and gynaecological wards.

5 Staff-housing is also insufficient. More junior medical staff need to be housed on site; the revenue consequences of having to pay in perpetuity for adjacent Local Authority housing, are enormous.

6 Generally, 'Best-Buy' was constructed 'regardless of revenue consequences' and is causing particular problems in terms of maintenance and repair. The courtyards are felt to contribute to this cost, although they are much appreciated by staff and patients alike.

Mainly the problem area has been poor materials of construction which have not stood up to the wear and tear of heavy usage.

7 Security has been and remains a difficult problem in the hospital. Losses of every sort of item run high (this is becoming a national trend), but the design of the hospital is felt to enable theft to take place more easily because of the number of entrances which can be left open at night unsupervised.

8 The main entrance is a good meeting area for people, but because the reception area is geared for admissions to out-patients only, there is a lack of focus for information and direction. A communications centre and staffed information centre are desperately needed.

9 The wards are generally liked, but their flexibility has been somewhat impeded by the multiple sets of fire doors. The zoning is felt to be totally illogical and is having to be altered.

Medical gases on the wards are welcome, but the number of outlets is insufficient. Because the hospital has much greater numbers of high dependency patients than expected, many more outlets are required. This is a consideration that requires special study.

10 The engineering services, as such, have had to be reviewed because the loading on them has vastly increased. This is partially due to a much greater use of equipment in every department.

Standby/emergency generation of power has been totally miscalculated, but the problem could not necessarily have been foreseen at planning stage. The services were supposed to support the hospital for an hour or so in the event of a breakdown of normal supply. Nowadays the hospital is felt to be very vulnerable to longer-term industrial relation disputes and the partial hospital emergency cover is not acceptable any longer.

11 As at Bury, the Catering logistics, departmental design and workflows are felt to require special study.

12 Day and Emergency and Central Treatment Suites are working quite well. They are not liked by everyone, but they take a considerable load away from other departments and are believed to help in reducing cross-infection and other problems.

13 The design of the hospital on two storeys with the relationship of the departments planned the way they are, is considered to be a surprising success. There are few problems about patient movement, and the feedback from the users is one of general appreciation and favour.

CONCLUSIONS

SUMMARIES

The following tables, summarise, in a very general way, the commentative conclusions of this study.

The results are related directly to the parameters of this research project, ie the 'Best Buy' objectives and the implications of development and change that affect them.

In this respect, then, the tables should be used in conjunction with the written conclusions not to criticise the hospitals but to point towards future design and planning - particularly in respect of population and service requirement estimates where a new DGH of similar size is being built.

The recommendations for further study again relate to project planning and not to study within these hospitals. Possibly they could form the basis for research in other hospitals, so that information of a similar nature from similar sources could be accumulated and discussed.

The tables should be read as:

✓ = correspondence with or antithetical to original objectives etc.

⇄ = tendency towards or away from " " " "

CONCLUSIONS

Summary Table

Hospital Departments/Services		Department-Design/Func Assessment of Satisfacti			Functional Policy			Success of Best Buy Objec			Recommendations for further study.
		+	↔	-	Pl.	Op.	New	+	↔	-	
General Acute Inpatients											
general	Bury	✓			←			←			✓
	Frimley		→				→	←			
obstetrics	Bury		←				→			→	✓
	Frimley			✓	←					→	
children	Bury		→				→	✓			
	Frimley	✓			✓			✓			
psychiatry	Bury		→		←					→	
	Frimley		→		✓			✓			
geriatrics	Bury	✓					→			✓	
	Frimley		→		←			←			
isolation	Bury	✓			←			←			
	Frimley	✓			←			←			
intensive care unit	Bury	✓			✓			←			
	Frimley		←		✓				→		
Outpatients and Day-patients											
general, dental & obstetrics	Bury			✓	✓					✓	✓
	Frimley			✓	✓					✓	
accident & emergency	Bury	←			✓				→		✓
	Frimley	←			✓				→		
day & emergency	Bury	✓			←			✓			
	Frimley	✓			←			✓			
Treatment and Diagnostic Services											
central treatment suite	Bury	✓			✓			✓			
	Frimley	✓			←			✓			
operating theatre suite	Bury	✓			←			✓			
	Frimley	✓					→	✓			
x-ray dept:	Bury	←			✓			✓			
	Frimley	←					→	✓			
pathology & mortuary	Bury	←					→	✓			
	Frimley	←			←			✓			
physical medicine	Bury			✓	←				→		
	Frimley			✓	←				→		✓

CONCLUSIONS

Summary Table

Hospital Departments/Services		Department-Design/Functio Assessment of Satisfaction			Functional Policy			Success of Best Buy Objectiv				Recommendations for further study.
		+	↔	-	Pl.	Op.	New	+	↔	-		
Pharmacy	Bury			✓		→	→			✓		✓
	Frimley		→			→	→			✓		
Catering & Dietetics	Bury			✓		→	→			→		
	Frimley		→		←			←				
Engineering, Works, Maintenance & Disposal	Bury	✓				→	→			→		✓
	Frimley		→			→	→			→		
Supplies, Storage, & Distribution	Bury		→				✓			→		
	Frimley	←					✓			→		
Education & Training	Bury		→		←					→		✓
	Frimley			✓		→	→			→		
Staff Facilities	Bury	✓			✓			←				
	Frimley	✓			✓			←				
General Amenities	Bury	✓			✓			✓				
	Frimley	✓			✓			✓				
Patient Services (medical records et.c.)	Bury			✓		→	→			→		✓
	Frimley	←				→	→			→		
Housekeeping	Bury		→			→	→			→		✓
	Frimley	✓			✓					→		
Administration												
general management	Bury	←			✓			←				✓
	Frimley		→		✓			←				
medical	Bury				←					→		✓
	Frimley		→				→			→		
nursing	Bury	←				→	→	✓				
	Frimley	←				→	→	✓				
portering/transport	Bury	←			←			←				
	Frimley	←			←			←				
voluntary services	Bury	✓			✓			✓				
	Frimley	✓			✓			✓				
social services	Bury	←			✓			✓				
	Frimley	✓			✓			✓				
Off sited Services												
laundry	Bury		→			→	→			→		✓
	Frimley	✓				→	→	✓				
c.s.s.d.	Bury		→			→	→			→		✓
	Frimley	✓			←					→		
supplies	Bury	←				→	→			✓		✓
	Frimley	←				→	→			✓		

Note:

In no way do the tables replace the detailed commentary of individual conclusions at the end of each section, they relate only to the terms of commission given to the research team.

CONCLUSIONS ON BEST-BUY OBJECTIVES

Finally, it is worth restating the major principles or objectives of Best Buy planning in order to demonstrate the findings of the evaluation.

Objective 1 : 'Function : to provide a basic hospital service which complements integrated community health services in an area'.

Both hospitals do, in fact, provide much more than 'a basic hospital service'. They have tended to become a focus for health care, and as such have been put under greater pressure than was anticipated. Greater efforts have been made to achieve co-ordination with the community health services and they have generally been successful. However, they are not fully integrated and access to them is very dependent upon the personalities of people involved. Where the hospitals work well, is in encouraging community health personnel to come into the hospital and use its facilities, this facilitates communication between the hospitals and the community.

Objective 2 : 'Economy : to build hospital as economically as possible without creating increased maintenance and revenue cost'.

This objective was considered by the evaluation team to have been a complete failure, the principal reason being that the maintenance and revenue costs have become enormous. The hospitals are difficult to maintain (partially from the services-engineers and work staff point of view) and savings at planning stage in specification of materials have resulted in a very poor performance of fabric and structure. Had the materials been more robust and the services more accessible this criticism would have been invalidated.

Objective 3 : 'Efficiency : to design hospitals as complete units placing individual departments in good functional relationship with one another. This ensured that when patients had to receive hospital attention it should be possible by the maximum use of out-patient diagnostic and treatment facilities including day beds, to treat more of them as out-patients'.

Reference should be made to the section on 'Outpatients'. The out-patients department is considered to be totally inadequately designed. It is difficult to organise sets of rooms so that consultants with attendant registrars and house officers can efficiently deploy themselves during any particular session. Additionally, and perhaps unfortunately, it was not foreseen at planning stage what an impact the changing of catchment area population orientation to the new DGH would have. The populations concerned have both increased in size, dramatically in Frimley's case, and this has put an enormous load on the out-patient services. One national problem affecting out-patient service is the unforeseen rise in incidence of venereal disease. These factors strongly indicate that a special review of out-patient needs in both areas should be considered.

However, having stated this, the principles of the relationship of the out-patients service to the other hospital facilities is excellent. The functional relationship between one department and another and between wards is generally very good, and is very much appreciated by staff and patients alike. Also, the plan has been able to accommodate changes in organisation, room-function and allocation and there is potential even for the internal 'core' departments to expand as the hospital develops.

Objective 4 : 'Quality : to build hospitals to a standard no higher than that required by clinical and amenity needs'.

Clinical needs for the most part have been satisfactorily fulfilled within the hospital.

Particularly the innovations of Best Buy planning including the Day and Emergency Unit and the Central Treatment Suite have proved successful in complementing the function of the wards and other departments. For detailed information, however, refer to individual sections.

Amenity needs are very satisfactorily fulfilled from the patients point of view. The staff appreciate their working environment but it is felt that the economies have deprived them of certain off-duty facilities, and more residences are needed than were provided.

Objective 5 : 'Environment: to create hospitals which engender a sense of well being for patients and staff.'

As far as we can tell this objective has been achieved. The hospitals are light, airy, pleasantly furnished, well appointed with courtyards and retain more of a character of domesticity than many other hospitals.

Objective 6 : 'Speed : to design and build hospitals as rapidly as possible, making optimum use of planners and designers'.

This objective has been achieved at a certain cost. The final capital costs were higher than anticipated and the structure of the hospital has proved rather poor in quality and a little inflexible in one or two instances. However, both Bury and Frimley have gained a very useful and comprehensive health facility at a crucial stage of their area health-care replanning ... 'it is a 100% bonus ... and it provides the basis for further development'.

Best Buy planning and construction has provided a useful and forward looking start to evaluating and building for health-care elsewhere.

The principal points of reference to the whole of the evaluation are the 6 objectives of Best Buy Planning:

Function
Economy
Efficiency
Quality
Environment
Speed

outlined in the document:

1 'Best Buy Hospitals' DHSS/COI : 1973 : HMSO

In addition the synopsis of the aims of providing the Best Buy hospitals - see 'METHODOLOGY' which was used in the interviews - was abstracted from two government publications:-

2 'Rationalisation of Planning and Design'
Ministry of Health - New District General Hospitals -
Bury St Edmunds - Frimley - March 1968

3 'Evaluation of Planning and Design'
Department of Health and Social Security -
New District General Hospitals -
Bury St Edmunds - Frimley - Report BB3 - March 1970

A further document provided detailed data for service requirement estimations:

4 'The Interrelationship of Hospital and Community Services in Best Buy Planning'
- DHSS - Report BB6 - May 1971

The principal reference used for monitoring the research team's investigation was:

5 'Best Buy Hospitals' - Bury St Edmunds and Frimley - Final Detail Planning Policies - DHSS 1968-1972

In addition the complete 'Commissioning Operational Policies' for Bury St Edmunds and a majority of the equivalent policies for Frimley were made available to the researchers.

6 'Best Buy Hospitals' - Paul James. Theme Feature - 'Built Environment'
December 1977

7 'Planning and Design of Best Buy Hospitals and Development of a Harness Design for District General Hospitals' B R Joseph - 'Hospital Engineering'
- June 1970

8 'Best Buy Hospital - Bury St Edmunds'
AJ Building Study - 19 June 1974

9 'The Hospitals and Health Services Year Book'
1974/1975/1976/1977/1978
Institute of Health Service Administrators

10 'Social Services Year Book' 1976/1977
Publ. Council and Education Press

11 'Questionnaire Design and Attitude Measurement'
A N Oppenheim. Publ. Heinemann 1968

12 'Evaluating New Hospital Buildings'
Kings Fund Centre. K Baynes et al. 1969

13 'Hospital Building Notes' No's 1 to 35
DHSS/HMSO 1962 onwards

14 'Health and Safety at Work Act' 1974
HMSO

15 'National Health Service - the Administrative Structure of the Medical and Related Services in England and Wales' Ministry of Health. HMSO 1968

16 'National Health Service - the future Structure of the National Health Service' DHSS. HMSO. 1970

17 'The Hospital Building Programme' Cmmd 3000
HMSO 1966

18 'National Health Service Reorganisation'- England
HMSO 1972

19 'The Organisation of Medical Work in Hospitals'
Ministry of Health. 1969

20 'The Organisation of the In-patients Day'
DHSS. HMSO. 1976

21 DHSS 'Annual Report' 1976. HMSO 1977

22 'The Way Forward - Priorities in the Health and Social Services'
DHSS. 1977

23 'District General Hospital at Frimley, Surrey - Description of Engineering Services'. DHSS Report BB5 (F) 1970.

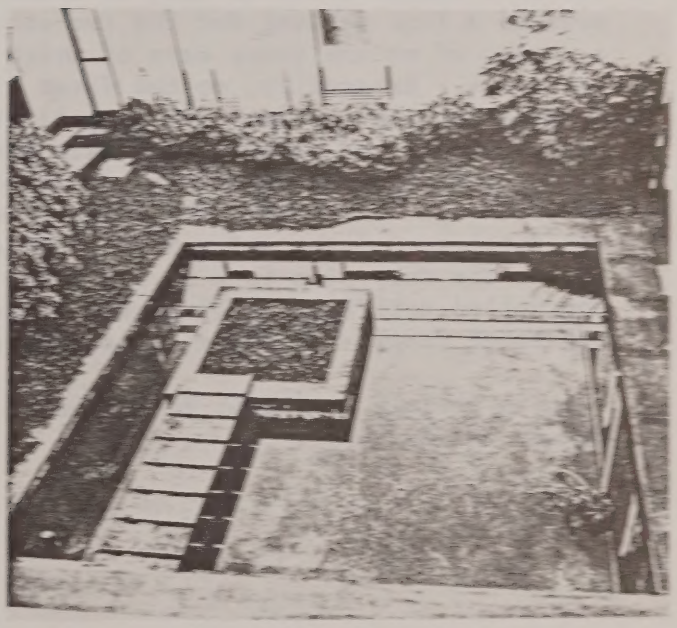
24 'District General Hospital at Bury St Edmunds, Suffolk - Description of Engineering Services' DHSS. Report BB5 (B) 1970

25 'Evaluation of the Supply and Disposal Systems at the Best Buy Hospitals'
MARU Hazel Grayson. 1978
- current research programme -

26 'Examples of Multi-use of Space in Hospitals'
MARU. 6/77 John Kelly. May 1977

27 'Space Utilisation in Hospitals'
MARU 5/77 Dr Carole Rawlinson. April 1977

Appendix 1: quality & environment.



The commentary on the quality and environment of the hospitals has extensively been discussed at the appropriate stage in each section of this report.

Detailed information, where available has been included on:

1 Performance of structure
2 Performance of environment
3 Finishes/damage
4 Changes of use
5 Scale
6 Interior design
7 Landscaping and courtyards

It is appropriate, therefore, at this stage, just to add very briefly what the architects were aiming towards in considering an aesthetic environment:-

'The 'Best Buy' design concept stemmed from a desire to secure better value for money put into hospital buildings; a conviction that ever larger, more elaborate, more expensive, 'one off' hospitals ought not to be regarded as the only way of meeting the constant pressure for renewals and replacements and improved health care facilities. Along with this attempt to minimise size and cost went a design approach aimed at reducing the visual impact of what was still a substantial building (total floor area of each hospital is 30,000 sq m) and providing a humane and reassuring environment for patients and staff.

The well wooded sites at Bury St Edmunds and Frimley (each over twenty acres) provide a fine setting for the two-storey buildings which are approached through a screen of mature trees many of which are more than twice the height of the buildings. Externally, on the first floor, are projecting bay windows, which provide sitting-up space for in-patients accommodated in each of the 6-bed bays of the wards. On entering the main entrance concourse, there are views of the first of some seventeen enclosed landscaped garden courtyards which provide natural light and air to the various departments within the U-shaped band and the feeling of light and air and contact with the world outside is maintained within the deep-plan form of the wards by the use of clerestory windows. A controlled artificial environment is provided only in special areas (eg theatres, treatment rooms etc) where it is required for medical reasons.'

From an article in 'Built Environment' December 1972. Paul James (Hospital Design Partnership).

Printed in England for Her Majesty's Stationery Office by Hobbs the Printers of Southampton
(1886) Dd8218006 K3 10/80 G3927